STATE TITLE V BLOCK GRANT NARRATIVE
STATE: MN
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The signed Assurances and Certifications are available upon request from:

Minnesota Deptment of Health
Maternal and Child Health Section
ATTN: Barb Kizzee
PO Box 64882
St. Paul, MN 55164-0882

Phone number (651) 281-9935

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

In Minnesota, the opportunity for public input into the MCH planning process is ongoing, utilizing a variety of methods at both the state and local levels. Information was shared routinely throughout the needs assessment activity to keep interested parties and partners informed and solicit input. The needs assessment process directly involved a total of 89 representative participants over multiple day retreats to establish the state priorities for 2005 -- 2010.

The Maternal and Child Health Advisory Task Force (MCHATF) provides a particularly significant source of input into overall state activities. This statutorily required advisory group, comprised of 15 members equally representing professionals, representatives from local public health, and consumer representatives, is charged with reviewing and reporting on the health care needs of Minnesota's mothers and children and recommending priorities for funding and activities. The MCHATF was included in the planning, implementation and analysis of the 2005 Needs Assessment at their regular quarterly meetings in 2004 and 2005 and several task force members were additionally involved in the prioritization retreats noted above and described in more detail in the needs assessment document.

Prior notice was made in the State Register, and on June 24, 2005, following the MCHATF quarterly meeting, a public hearing was held on the Title V MCH Block Grant.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Minnesota is seen as a state where the people enjoy a high quality of life and experience generally better measures of health compared to most other states. Minnesota consistently ranks as one of the most desirable and healthy states in which to live and work. When parents are asked about the overall health status of their child, 90.4% report that it is excellent or very good (compared to 84.1% nationally .) Seventy-eight percent of Minnesota's children have mothers in the work force compared to 69 percent nationally--which may be related to the fact Minnesota has the highest percent (25.6%) of children ages 6 to 11 who stayed home alone. Minnesotans are engaged in their communities; the voter turnout in Minnesota for the 2004 elections was the highest in the nation.

Minnesota is however experiencing the same pressing economic challenges being felt across the country. The 2003 legislative session opened facing a $4.5 billion shortfall, which was resolved primarily with program cuts -- many of which settled heavily on maternal and child populations. Minnesota's publicly funded health insurance programs such as Medical Assistance and MinnesotaCare, its TANF program, local public health funding, and state's social services programs either had reductions in budget or changes in eligibility criteria - most set to begin July 1, 2003. The most recent 2005 legislative session opened facing an additional $466 million budget deficit. The legislature is in an extended session working to make painful choices and decisions.

Demographics Minnesota is a medium-sized state, encompassing slightly more than 84,000 square miles. Minnesota's per capita income in 2003 was $34,039, the eighth highest in the country. The 2003 unemployment rate was 5% compared to the national rate of 6%. While it remains a major agricultural producer, Minnesota's economy is also driven by service sector industries such as healthcare, manufacturing, financing, insurance, real estate, and wholesale and retail trade. The workforce sustaining this economy comes from a population (2000 Census) count of 4,919,479 people, making Minnesota the 21st most populous state in the nation. Fifty-four percent of the states residents live in the seven-county, Minneapolis-St. Paul metropolitan area. Minnesota has seven metropolitan statistical areas (MSAs) where seventy percent of the population lives. 65 percent of the statewide population increase of 544,380 that occurred between 1990 and 2000 took place in this seven-county Twin Cities area. American Indians comprise a significant proportion of the population and cultural heritage of Minnesota. According to the 2000 US Census, 58,192 American Indian or Alaska Natives lived in the state, of these, 32,029 were children. In 2000, approximately half of the American Indian population lived on seven Chippewa and four Dakota reservations, while the remainder lived in major population centers and communities spread across the state.

Minnesota's population is aging. Overall, Minnesota's age distribution is similar to the national average, but there were some marked differences in age group trends between Minnesota and the U.S. between 1990 and 2000. The median age of Minnesota is 35.4 and the United States median age is 35.3. Minnesota's median age is expected to rise to 41.3 by 2025. The elderly population grew much slower in Minnesota than nationally. The under 10 population also grew less in Minnesota than in the nation. The under-5 population showed a 7 percent gain in the U.S., while falling 2 percent in Minnesota. The 5-to-9 group went up 14 percent nationally but only rose 3 percent in Minnesota. In contrast, Minnesota had stronger than average growth in almost every age group from 15 to 64. The biggest difference was among 15 to 19 year-olds. This population went up 26 percent in Minnesota, much higher than the 14 percent gain nationally.

Demographically, Minnesota had a relatively homogenous racial and ethnic population for most of the twentieth century. This is changing, and although the absolute numbers of populations of color are small, the rate of change is not. In 2000, Populations of Color represented 10.6 percent of the total population in Minnesota as compared to 5.6 percent in 1990. By 2025 it is estimated that non-White population will represent 17 percent of the State's population . Between 2005 and 2015, the nonwhite population is projected to grow 35 percent, compared to 7 percent for the white population. The Hispanic Origin population is expected to increase 47 percent

Minnesota's immigrant populations continue to increase. In the late 1970's Minnesota began to see a new wave of international immigration. Following the end of the war in Vietnam, large numbers of refugees from Southeast Asia began to arrive in Minnesota. After the fall of the Soviet Union in 1991, an increased number of refugees came from Eastern Europe. The hostilities in Bosnia-Herzegovina brought more refugees from what was Yugoslavia. Famine and civil war bring large numbers of refugees from Africa. Minnesota's non-profit organizations are welcoming and provide needed services and support to these newcomers, and Minnesota has become a prime destination for refugees. During this same period of time, immigrants came to Minnesota to work in high tech industries. Large numbers of people came from India, China, and Pakistan. These well-educated and well-trained immigrants were hired in the 1990's by the booming technological companies throughout the state.

In the most recent data (federal fiscal year 2002) from the Office of Immigration Statistics, 13,522 immigrants came to Minnesota from 160 different countries and every continent except Antarctica. Minnesota's major immigrant populations include: Latinos, Hmong, Somalis, Vietnamese, Russians, Laotians, Cambodians and Ethiopians. Many immigrants come here from other states. The effects on Minnesota have been far reaching with visible changes in small towns and cities, schools and businesses. These eight national origin, ethnic or language groups noted above each represent more than 1,000 children in Minnesota's schools in the 2003-2004 school year. As an example, in the town of Pelican Rapids, with a population of 1,900, there are now 24 languages spoken.

These significant demographic changes such as the aging of its population, concentration of various populations in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population) will impact not only the need for and the type of healthcare, but will also affect housing, education, business, commerce, employers and social services.

Economics - Poverty In Minnesota there are 718,474 families with related children under 18 years, with 1,186,982 children. Eight percent of children live in poor families, compared to the national percent of 17%. Twenty-four percent of children live in low-income families, compared to 38 % nationally. Fifty-six percent of these children have at least one parent who is employed full-time annually. Only 9% of children in low-income families do not have an employed parent . The number of children eligible for the free/reduced price school lunch has been increasing, from 24.7% in 1992-1993, to 26.4% in 1996-1997, to 28.5 % in 2001-2002. WIC enrollment has been increasing steadily over the past several years. April enrollments for the past 3 years have grown from 111,717 in 2003, to 116,308 in 2004, to 123,643 in 2005.

Health Disparities While Minnesota enjoys a high level of health status indicators overall, there are significant and highly concerning disparities in health status measures for populations of color and American Indians -- particularly in outcomes related to women and infants. Because the health status of mothers and infants is highly affected by the social conditions in which they live, it is also important to make note, at least generally, of some of these key indicators, which all show disparities to the disadvantage of populations of color and American Indians. Table 1 provides an overview of some of these social condition indicators.

Table 1: Social Condition Indicators by percent for Select Populations in 2000

	African American	American Indian	Asian	Hispanic	White
Poverty	27.1	28.6	18.9	20.1	6.7
Poverty -- children <18 yrs	34.2	35	24.3	23	6.2
Unemployment -- males/females	11.7 / 12.0	15.7 / 14.0	5.3 / 5.4	7.7 / 8.7	4.2 / 2.9
Education -- less than high school	21	25.5	28.8	41.9	10.8
Education-bachelor/advanced degree	18.7	8.8	36.1	14.0	27.9
Housing -- own	32	49	52.3	42.9	77.2
Housing -- pay >50% of income	22.6	18.9	15.0	15.1	14.6

In 2003 the self-identified racial composition of women who gave birth was mostly white (84%). The remaining 16% of the women who gave birth self-identified as African American (7.6%), Asian (5.5%), and American Indian (2.0%). The birth rate per 1000 teens 15-19 years old for 2001 -- 2003 varied by race as follows: African-American 122.1; American Indian 112.4; Asian 67.9; Hispanic 129.8; and White 29.4 . According to 1997-2001 Minnesota birth certificate data, rates of inadequate/no prenatal care are three to four times higher among populations of color in Minnesota (African Americans (12.4%), American Indian (17.4%), Asian (9.8%), and Hispanic (11.2%) compared to such rates for white pregnant women (3.2%) .

Between the time periods 1989-1993 and 1997-2001, the percent of premature births decreased in all racial/ethnic groups except for White, which increased slightly. However disparities still exist so that approximately 1 of 10 African American, American Indian and Asian babies are born premature compared to 1 in 14 White and Hispanic babies . The change in low birth weight (under 2500 grams) from 1989-1993 to 1997-2001 have been less than one percent for all racial and ethnic groups except African Americans, where the LBW decreased from 11.5 to 9.1 percent. This is still the highest disparity in comparison to low birth weights for American Indians at 5.8 percent, Asians at 6.4 percent, Hispanics at 4.8 percent, and Whites at 4.0 percent.
Mortality rates for infants and mothers differ greatly by race and ethnicity. Based on 1996-2000 data neonatal mortality rates (deaths that occur before the 28th day of life) are particularly disparate between African Americans (8.5/1,000), American Indians (6.2/1,000) and whites (3.4/1,000). In other words, African American neonates are 2.5 times more likely and American Indian neonates are 1.8 times more likely to die than their white counterparts . In Minnesota, American Indian (5.7/1,000) and African American infants (4.2/1,000) suffer much higher rates of postneonatal mortality (deaths that occur from 28 to 365 days of life) compared to White infants (1.7/1,000) .

Maternal mortality rates are based on women who die while pregnant or within one year of termination of pregnancy, irrespective of cause. Based on 1990-1999 data, African American women died of pregnancy-associated issues at a rate 2.4 times higher than the white rate. The American Indian women's pregnancy-associated death rate was 2.8 times the white rate.

Insurance - Access Minnesota continues to maintain one of the lowest rates of uninsured populations in the nation. Some recent information however is showing some potentially negative changes in those rates. Based on the 2004 Minnesota Health Access Survey, there is a general increase in uninsured Minnesotan's (from 5.4% in 2001 to 6.7% in 2004). This increase was driven by a decrease in employer-based health insurance coverage, a shift in Minnesota's income distribution, and a change in Minnesota's Hispanic/Latino population. In 2004, Minnesotans were more likely to be uninsured or covered by public health insurance programs and less likely to be covered by group or employer-based health insurance coverage than they were in 2001. Rates of uninsured continue to show disparities based on race, with the change being most pronounced for Hispanic/Latino Minnesotans.

Results from the Minnesota Health Access Survey of 2004 show some significant changes between 2001 and 2004 of insured rates for women and children. Between 2001 and 2004 uninsured rates increased for all children (birth-17) from 6.4% to 7.7%. In the Black population (birth-17) uninsured rates decreased from 16.9% to 12.4 %, but this is still double the White rate of 6.4%. The overall non-White uninsured rate for 2004 is 16.0% with Hispanic being highest at 31.6 % (up from 19.7% in 2001).

Within the birth to 5 year old group, the uninsured rate rose from 5.7% in 2001 to 9.2% in 2004. The non-White rate remained relatively stable, while the White rate increased from 4.2% to 8.0%. This Birth to 5 year old uninsured rate is higher than the overall uninsured rates for the 6-12 age group (7.0%) and the 13-17 age group (7.1%). It is too early to tell whether these rates may have been influenced by policy changes from the 2003 legislative session, which went into effect on 7/1/2003. The Children's Defense Fund of Minnesota estimated these policy changes would negatively impact the insurance status for 20,000 children.

This study also indicated that rates of uninsurance for women in the childbearing years (15-44) increased from 11.5% to 12.8% overall. Table 2 describes these changes for women.

Table 2: Percent uninsured at some point in the year for women 15-44 years of age -- by race/ethnicity

Population	2001 - %	2004 - %
Women 15-44 overall	11.5	12.8
White	10.2	10.6
Black	28.9	27.5
Hispanic	31.0	42.8
Other	18.4	17.1
All Non-White	24.4	26.9

State funded health programs Minnesota provided health insurance coverage for roughly 654,000 state residents at some point during state fiscal year 2004 through it's three publicly funded basic health care programs -- Medical Assistance (Minnesota's Medicaid program), General Assistance Medical Care (GAMC), and MinnesotaCare. The Minnesota Department of Human Services (DHS) administers MinnesotaCare and oversees MA and GAMC, administered by counties. About 70 percent of DHS's budget is devoted to these three programs. About half of enrollees in all programs combined are children under 21.

Medical Assistance (MA) Medical Assistance is the state's Medicaid program and provides acute, chronic and long-term care services to low-income seniors, children and families, and people with disabilities. Families, children and pregnant women account for 69 percent of Minnesota's MA enrollees, but account for only 22 percent of its expenditures. The majority of expenditures, more than 78 percent, are for people who are elderly or have a disability. Program expenditures for state fiscal year 2004 totaled $4.99 billion, of which the federal share was $2.63 billion. MA provided coverage for a monthly average of $464,000 in FY 2004. The average monthly enrollment of children was 321,291.

The state currently operates its Medicaid program with one Section 1915(a) waiver, one Section 1915 (b) freedom of choice waiver, six Section 1915(c) home and community based waivers, and one Section 1115 waiver. The Section 1115 waiver is the state's MinnesotaCare Health Care Reform Waiver. The TEFRA waiver allows some children with disabilities who live with their families to be eligible for Medical Assistance without counting parent's income. Also the Home and Community Based Waiver programs allow some children with disabilities who live with their families to be eligible for Medical Assistance without counting the parent's income. Medical Assistance for Employed Persons with Disabilities allows working children with disabilities who are at least 16 to quality for Medical Assistance under a higher income limit.

The central Medicaid 1115 waiver is the state's PMAP waiver. The Prepaid Medical Assistance Program (PMAP) began in 1982 when Minnesota was selected by the federal Health Care Financing Administration (HCFA) as one of five original states to implement managed care for non long-term care services for designated Medicaid populations on a prepaid, capitated basis. Populations covered by the now statewide PMAP program include families with children, elderly, children in foster care placement, and on a voluntary basis, children eligible for MA through subsidized adoptions, and children who are seriously emotionally disturbed and who are eligible for MA-covered targeted case management. There is federal financial participation for coverage of pregnant women and children in the MinnesotaCare program (described later in this section). As of December 2004, 83 of Minnesota's 87 counties were participating in the PMAP+ program. A 1997 state law authorized all counties to choose the type of Medicaid managed care model to be implemented in their county: either PMAP or County-Based Purchasing. County-based purchasing would allow counties (instead of the state) to purchase and/or provide comprehensive Medicaid services on a risk basis contingent upon federal 1115 waiver approval.

Minnesota has received approval for an 1115 waiver demonstration project for family planning that is being planned for implementation on July 1, 2006. This will provide eligibility for family planning services, including treatment for STIs identified in a family planning visit, to women and men at or below 200% FPG and provide automatic extension of family planning coverage for one year to anyone who loses MA or MinnesotaCare coverage.

MinnesotaCare MinnesotaCare is a state subsidized managed care program funded by a tax on hospitals and health care providers, federal Medicaid matching funds, and enrollee premiums and co-payments. Medical payments for MinnesotaCare totaled $487 million in FY 2004, with average medical payments per enrollee of $273 a month. The average monthly MinnesotaCare enrollment in 2004 was 148,000. Families with children are eligible for the program on a sliding-fee scale if their family is income and asset eligible. There is no asset limit for pregnant women or children. Federal financial participation is claimed for pregnant women and for children and benefits for these two populations are the same as those provided for under the Medical Assistance (Medicaid) program. Federal financial participation is also claimed for parents and relative caretakers enrolled in MinnesotaCare.

Erosion or crowd-out barriers consist of essentially three eligibility provisions. First, children, families and pregnant women must be permanent residents; families without children must not only be permanent residents, but also must have resided in the state for six months prior to enrollment. Second, individuals cannot have had other health coverage for four months prior to enrollment except for children in families with income at or less than 150 percent of FPG or for individuals making a transition to MinnesotaCare from MA or GAMC. The third eligibility provision denies, with certain exceptions, eligibility for individuals who have had access to employer subsidized insurance (50 percent or more of premium cost) through a current employer in the 18 month period prior to enrollment in the MinnesotaCare program. In response to the state's budget deficit, a more limited benefit set was established for adults without children. As a budget reduction strategy, effective 10/1/03 benefits limitations were added to hospitalization, physicians, drugs, outpatient services and lab/diagnostic services. A $10,000 limit on hospital care with a 10 percent co-pay requirement was added. In addition, premiums were increased for all populations using the program.

General Assistance Medical Care (GAMC) GAMC is a state funded program that covers acute care services for residents not categorically eligible for MA but who meet income and asset standards comparable to the medically needy standards of the MA program. The program provides coverage for most, but not all, of the same health services offered by the MA program. Individuals who may be eligible include adults with no dependent children, adults residing in group resident housing, adults awaiting a determination of disability, and adults participating in the state's General Assistance program. In 2004, GAMC provided medical care for a monthly average of 34,900 low-income Minnesotans - primarily low-income adults, ages 21-64, who have no dependent children. Expenditures in FY 2004 were $245.6 million, with average medical payment for a GAMC enrollee of $587 a month. As part of the state's response to the budget deficits of the last few years, effective 10/1/03 eligibility for GAMC was lowered from 175 % of federal poverty level (FPL) to 75 % of FPL. A new "catastrophic" health program for individuals between 75 % of FPL and 175 % of FPL was established but, to cover hospitalization costs only and includes a $1,000 deductible.

In response to the severe budget shortfalls, changes were made in the 2003 and 2004 Legislative sessions to these public health care programs that have had a significant impact on mothers, children and children with special health care needs. Beginning July 1, 2003, parental fees for children on the TEFRA waiver program were increased -- in some cases by more than 1,000 %; waiver slots for MR/RC, TBI, CADI were reduced or capped; and services to adults were modified, requiring co-pays for drugs, doctor visits and non-emergency emergency room visits while dental care was limited to $500 per year. Beginning July 1, 2004, Medical Assistance income eligibility for pregnant women went from 275 % of FPL to 200 % of FPL, and MA income eligibility for children ages 2 through 18 was lowered from 170 % FPL to 150 % FPL. Infants born to mothers on MA now qualify for one year of automatic eligibility rather than two years. In October 2004, it became necessary for children enrolled in MinnesotaCare and Minnesota's Section 1115 waiver programs to reapply for coverage every six

months, rather than the previous 12 months. The Department of Human Services estimates that in FY 2007 this change will reduce the average monthly enrollment in MinnesotaCare by 6,000 children.

As families come off of MA, the data does not indicate that they are enrolling in MinnesotaCare as an alternative. Overall, MinnesotaCare is seeing a steady decline in enrollment numbers since July 2003, when most legislative cuts were implemented. There was a 6% decrease in enrollment numbers for children under 21 from August 2003 (70,447) to August 2004 (66,019).

Effective 7/1/2003 changes were made to General Assistance Medical Care (GAMC) and Emergency GAMC was eliminated, leaving 2,200 of Minnesota's poorest children with no health insurance or source of regular care. In the second half of 2003, coinciding with these cuts to GAMC, Hennepin County (largest populated county) experienced a 39% increase in uninsured patients requiring inpatient services and an 8% increase in those requiring outpatient services. After July 1, 2003, Hennepin County's Assured Access Program (not insurance, but enables enrollees who are uninsured and ineligible for public programs to receive discounted services from participating community clinics) saw an increase in enrollment for children of 55%.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) are areas that are federally designated as lacking adequate health care services. Populations in 54 out of 87 counties are in federally designated Health Professional Shortage Areas (HPSAs) for primary care. 73 counties include either a HPSA or an MUA designation or both. Additionally, populations in 41 counties are in dental HPSAs and populations in 70 counties are in mental health HPSAs. While some of these designations are in urban areas with high percentages of poverty and minority populations, the majority are located in frontier and rural counties in the state. These areas tend to lack employment opportunities and experience a higher rate of uninsurance than other areas in the state. See the HPSAs maps on the following websites. The first one is rural at http://www.health.state.mn.us/divs/chs/DDHPSADec04.jpg and the urban map is at http://www.health.state.mn.us/divs/chs/MetroDentDec04.jpg. Also the Medically Underserved Areas can be seen at http://www.health.state.mn.us/divs/chs/MUASept04.jpg for rural areas and http://www.health.state.mn.us/divs/chs/MetroMUAFeb05.jpg showing urban area.

HPSAs and MUAs help meet the health care needs of medically underserved rural and urban populations of Minnesota by supporting the health care safety net services. Clinics located in these areas and providing health care services to underserved population can meet eligibility criteria for a number of federal and state assistance programs, including grants and reimbursement incentive programs.

TITLE V PROGRAM ROLE

The role of the Title V program in the state's health care delivery environment is to assess the health needs of mothers, children, and their families and to use that information to effectively advocate on their behalf in the development of policies concerning organizational and operational issues of health systems, and to advocate for programs and funding streams which have the potential to improve their health. The state's Title V program does have a significant assurance role. The Title V program areas of MCH and CSHN administer, coordinate and support many activities addressing maternal and child health, including the Title V Block Grant. The maternal and child health responsibilities of the Division include statewide planning and coordination of services through the acquisition and analysis of population-based data, the provision of technical support and training; coordination of various public and private efforts; and support for targeted preventive health services in communities with significant populations of high risk and low income families.

Program goals described in a later section are accomplished through partnerships with both state and local level agencies. The Department has interagency agreements with the Department of Human Services related to Title V/Title XIX activities, and also partners with local Community Health Boards, the Minnesota Department of Education, Economic Security, Corrections, and Public Safety. Along with many other institutions of higher education, Minnesota is fortunate to have an excellent School of Public Health at the University Of Minnesota's Twin Cities campus. The close working relationship

with this school, particularly with the MCH and nursing programs, provides resources for both members of this partnership and future MCH practitioners.

CURRENT DEPARTMENTAL PRIORITIES/INITIATIVES
As the Minnesota Department of Health positions itself for the next years of this decade, legislative and gubernatorial direction as well as community- and population-based health issues will shape its priorities. The current governor, Tim Pawlenty, has identified health prevention as a priority, with a specific emphasis on obesity. The MDH administration, through it's Health Steering Team (HST), made up of the Executive Office staff and Division Directors, has undertaken strategic planning activities which led to the development of work groups to review these priorities: 1. Vision for MDH; 2. Organizational Structure; 3. Regulatory Roles, Responsibilities and Process; 4. Defining a Coordinated Process for Pursuing Funding for MDH Priorities; 5. Interagency Initiatives; 6. Providing Optimal Support to Local Agencies Responsible for Public Health; and 7. Data Collection.

Throughout 1998 the Department undertook a comprehensive effort to revise the state's public health goals and objectives and published Strategies for Public Health . This document is a compendium of ideas, experience and research offered to help local public health and other community agencies achieve the objectives of Healthy Minnesotans, 2004. Work is now underway to update this document for a Healthy Minnesotan's 2010. Title V will update the Goals and Strategies impacting maternal and child health populations.

Initially established in the Community Health Services Act of 1976, Minnesota has a strong public health infrastructure system of locally operated public health agencies and a good relationship between the state and local entities. As part of this original CHS Act, the Minnesota Legislature created the State CHS Advisory Committee (SCHSAC) that provides recommendations to the Commissioner of Health. This statute was revised in 1987 to create the Local Public Health Act, and again in 2003 when significant administrative changes were made.

These revisions included changes in funding for local public health wherein eight funding sources were combined in order to achieve administrative efficiencies, better target local priorities, and move towards results-based accountability. These grants are: the Community Health Services Subsidy, Maternal and Child Health state dollars, WIC state dollars, the Infant Mortality Grant, the Family Home Visiting Grant, the TANF Youth Risk Behavior Grant, the MN ENABL grant, and the Eliminating Health Disparities Grant to Tribal governments. The combined funds are distributed through two formulas -- one to city and county-based community health boards and one to Tribal governments. Additionally, these administrative changes necessitated planning to create accountability measures -- through development of statewide outcomes associated with a list of essential activities, as well as a revised reporting system. Title V staff have been very actively involved in the planning and development of these changes. Through this work six broad areas of public health responsibility were defined: assure an adequate local public health infrastructure; promote healthy communities and healthy behaviors; prevent the spread of infectious disease; protect against environmental health hazards; prepare for and respond to disasters and assist communities in recovery; and assure access and quality in health services. Title V related work is found in all six responsibilities. More information on this significant planning and infrastructure building activity can be found at http://www.health.state.mn.us/phsystem.html#essential A schematic representation on Minnesota's local public health improvement process is available http://www.health.state.mn.us/cfh/na.

Decision-making Processes
There are a number of institutionalized forums that allow the Commissioner of Health, and the Community and Family Health Division Director to remain up-to-date on the social, political and economic dynamics affecting health care issues. All of the groups described below provide for a statewide perspective of various stakeholders on different policy issues, which affords the Title V Directors a number of different vehicles for defining problems and policy and for feedback on recently enacted policy.

1. The Health Steering Team (HST) HST consists of the health department's Executive Office staff and the Division Directors. It meets monthly to provide input into departmental policies, determine priorities, and to identify and resolve issues.
2. The Maternal and Child Health Advisory Task Force (MCHATF) is a statutorily created standing advisory committee that assists the Commissioner of Health on selected policy issues. It is a 15-member group equally represented by consumers, maternal and child health professionals, and community health agency members with ex-officio representation from the Minnesota Department of Human Services; the Minnesota Department of Education; and the University of Minnesota MCH Program. Its purpose is to advise the Commissioner, the Division Director and the Title V program on the health status and health care needs of mothers and children. In 2005 the MCHATF created two priority work groups to focus on: 1. monitoring the impact of the 2003-2004 Legislative Session policy and budget changes, and 2. maintaining and improving early childhood programming.
3. The State Community Health Services Advisory Committee (SCHSAC) is a standing advisory committee comprised of county commissioners and local community health administrators. It meets at least four times a year and its purpose is to advise the Commissioner of Health on all matters relating to the development, maintenance, funding and evaluation of the local public health system. Each year the SCHSAC forms 3-5 work groups comprised of local public health experts to address topics of pressing interest to local public health agencies. It also sponsors an annual statewide conference for state and local public health professionals.
4. The Rural Health Advisory Committee consists of legislators, rural providers, and consumers. Its purpose is to advise the Commissioner and other state agencies on rural health issues and rural health planning. It too carries out its responsibilities through work groups. Their current focus is on mental health issues in rural communities.
5. Title V/Title XIX: The senior program managers for the Title V and the Title XIX programs meet quarterly to discuss maternal and child health issues and proposed changes in their respective programs and concerns due to changes in federal and/or state policy. The Title XIX agency is also the designated Title XXI agency.
6. The Management team of the Division of Community and Family Health meets on a monthly basis to resolve immediate operational issues and to discuss and define long-range issues.

B. AGENCY CAPACITY

The mission of the Community and Family Health (CFH) Division is to provide collaborative public health leadership that supports and strengthens systems to ensure that families and communities are healthy. This is done by partnering to: ensure a coordinated state and local public health infrastructure; improve the health of mothers, children and families; promote access to quality health care for vulnerable, underserved and rural populations; and provide financial support, technical assistance, accurate information and coordination to strengthen community-based systems.

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments, fully equipped to address the changing needs of the public's health. Minnesota Statutes Section 144.05 gives authority to the Commissioner of Health to develop and maintain an organized statewide system of programs and services to protect, maintain and improve the health of Minnesotans. This includes authority to collect data, prevent disease and disability, establish and enforce health standards, train health professionals, coordinate local, state and federal programs, assess and evaluate the effectiveness and efficiency of health service systems and public health programs in the state, and advise the governor and legislature on matters relating to the public's health. The language within Chapter 145 lays out the state requirements for the distribution of the Maternal and Child Health block grant, with two thirds to go out to local Community Health Agencies through a formula; establishes the MCH Advisory Task Force; and articulates program requirements for use of state funds for WIC, family planning, abstinence education, fetal alcohol syndrome, and home visiting. The Minnesota statute articulates that a third of the block grant money retained by the Commissioner of Health may be used to: 1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report; 2) collect and disseminate statewide data on the health status of mothers and

children within one year of the end of the year; (3) provide technical assistance to community health boards in meeting statewide outcomes; (4) evaluate the impact of maternal and child health activities on the health status of mothers and children; (5) provide services to children under age 16 receiving benefits under Title XVI of the Social Security Act; and (6) perform other maternal and child health activities as listed in federal code for the MCH block grant and as deemed necessary by the commissioner.

The delivery of primary and preventive health care services by local government in Minnesota occurs within a framework governed by "Community Health Boards." The Boards themselves are comprised of elected officials, either county commissioners or city council members, although the Community Health Boards have the authority to appoint non-elected officials to the Board. The Boards provide policy formulation and oversight of the local public health administrative agencies which are responsible for conduct of public health core functions and delivery of community public health services directly or through contracts. Program services include disease prevention and control, emergency medical services, environmental health, health promotion, home health and family health. There are 52 Community Health Boards in the state including 26 single-county boards, 61 counties cooperating in 21 multi-county boards, four cities, and one city-county board. This infrastructure provides for a community-based decision-making process based on a needs assessment with state leadership and support. The process recognizes differences among communities and provides a flexible range of responses. Core funding is provided by an ongoing state subsidy. However the majority of funding comes from local sources: $21 million state subsidy, $10 million in federal categorical funds, $57 million local tax levy, with the balance made up of grants, 3rd party payments, fees, etc., totaling approximately $292 million annually in 2004.

CROSS-CUTTING TITLE V PROGRAM CAPACITY
The MCH Advisory Task Force The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 to advise the Commissioner of Health on the health status and health care services needs of Minnesota's mothers and children, and the distribution and use of federal and state funds for MCH services. Fifteen members are appointed by the Commissioner with five each representing MCH Professionals, MCH consumers, and Community Health Boards. Terms are four years, half coterminous with the governor's term and half one year later. Work groups of the Task Force are often convened with a specific charge to bring back to the full Task Force recommendations made following more in-depth research and discussion. Current work groups of the MCHATF include monitoring the impact of the 2003-2004 legislative session policy and budget changes on mothers and children, and improving early childhood programming.

MCH Epidemiology A newly formed data/epi team was created in response to recommendations made during the 2003 CAST 5 data capacity process. The purpose of the team is to provide a broad base of technical expertise and support for data-related activities (e.g., needs assessment, research, program evaluation) to CFH staff with emphasis on building the capacity of staff to work with data through one-on-one coaching, consultation,and division-wide trainings. The team consists of 3 PhD level staff: the SSDI research scientist, another research scientist, and an epidemiologist. This team brings increased methodological and analytic capacity and will leverage efforts to advance SSDI project objectives; specifically, improving utilization of program data to assess needs and guide Title V efforts related to health disparities; increasing data linkages and use of linkages; and, providing analytic support and shared leadership for the PRAMS project.

The Data/Epi team has been actively partnering with programs on data activities, working on committees, organizing training opportunities, and developing structures for increased collaboration and data sharing within and across programs. Among the new structures formed is a Data Users Group, which is intended to foster communication and collaboration among researchers, analysts, policy planners, and others responsible for data utilization in and outside of the MDH.

MCH Special Projects Grant The Maternal and Child Health Special Projects (MCHSP) grant program was created in 1985 to meet the legislative requirement to distribute two-thirds of Minnesota's share of the federal MCH Title V Block Grant and an appropriation of state general funding to Minnesota's

Community Health Boards. MCHSP funds provide core funding for support of local public health infrastructure focused on the improved health of mothers, children, and their families. The program also targets funds to serve high-risk and low-income individuals in statewide priority service areas: improved pregnancy outcomes, family planning, children with handicapping conditions/chronic illness, child and adolescent health, and childhood injury prevention. The 2003 Legislature consolidated MCH dollars, along with seven other categorical programs, into the resulting Local Public Health Grant (LPHG) that provides funding for Community Health Boards and Tribal Governments. Accountability for MCH block grant dollars remains separate within this LPHG structure. Use of MCH Block Grant funds within this LPHG are limited to the statewide priority areas described above. Local match for the MCH funds was raised from 25 percent to 50 percent.

Tribal Governments While the Department of Health and the Division of Family Health have been working with tribal governments for some time, the process became more formalized in 2003 with the establishment and the hiring of a Tribal Liaison. Located within the Office of Minority and Multi-Cultural Health, the position is uniquely situated to establish stronger ties with Tribal Governments and Tribal Health Directors. Legislative action in 2003 acknowledged the role Tribal Governments play in the health status of their communities by including them in the Local Public Health Grant. In response to the significant disparities in infant mortality, childhood obesity, teen suicides and teen pregnancies, tribes were directed to use the new money in this grant for maternal and child issues. Title V staff work closely with and through the Tribal Health Liaison to provide technical assistance and support to the Tribal health staff and programs for all three MCH population groups.

The Mental Health program area supports ongoing implementation of the statewide suicide prevention plan activities including grant administration, K-12 and American Indian suicide prevention work groups, and technical assistance and information dissemination to local public health, schools, and other community-based entities. Additionally, this staff supports the mental health promotion activities incorporated throughout Title V program areas, e.g. maternal mental health, infant mental health, child social emotional development, screening and early identification, and healthy youth development. This staff represents the department on mental health committees and work groups and also provides support and expertise for interagency mental health policy and planning activities out of the executive office around mental health systems and issues.

The Dental Health Program provides oral health promotion training, technical consultation and assistance to professionals, and educational materials to Community Health Boards, schools and the general public. Program staff partners with the Department of Human Services in areas of dental policy and access issues and has good working relationships with the Minnesota Dental Association, the Minnesota Dental Hygienists Association, and the Minnesota Board of Dentistry. Additionally, the dental program staff works with; 1) water engineers and other individuals sharing community fluoridation responsibilities; 2) school and community leaders to expand and enhance school-based or school-linked dental sealant programs and oral health information and services linkages; 3) oral health advocacy groups to establish statewide oral health monitoring systems and oral health research projects; 4) oral health care providers to address the significant issues surrounding dental access; and 5) medical primary care providers to boost attention to the significance of oral health and overall well-being. With funding from HRSA, Minnesota Children's Oral Healthcare Access Project grant promoted the oral health of pregnant women and young children, to improve the early oral health status of infants and children served by Minnesota WIC program, and improve the awareness and anticipatory guidance skills of WIC parents related to the oral health needs of their children.

In addition to specific program areas listed below, Title V staff and programs work to leverage capacity by partnering with related programs situated in other Divisions within MDH. These include lead screening and abatement, Birth Defects Information System, immunizations, STI and HIV programs, breast and cervical cancer control, asthma, several health promotion program areas, the methamphetamine program, and children's environmental health.

POPULATION CAPACITY: PREGNANT WOMEN, MOTHERS AND INFANTS
Perinatal - The perinatal focus of work involves program staff with health providers to develop quality

preconception, family planning, prenatal, perinatal, and genetics services that increase the potential for healthy pregnancies and newborns. Staff assess needs, develop standards, and provide technical support services, training, and public education. This component assures counseling and education for patients and family members with known or suspected genetic diseases; assures genetic consultation, education and diagnostic support to physicians and other health professionals; and partners with the Public Health Laboratories program for detection of metabolic diseases through newborn screening. The infant mortality staff provides education, information and assistance to community and Tribal public health, works closely with Twin Cities Healthy Start, and with the MDH Office of Minority and Multi-Cultural Health in their Eliminating Health Disparities Initiative in the area of infant mortality reduction. Infant mortality staff are active with the Prematurity Campaign of the March of Dimes and with the Minnesota Perinatal Organization and work with the Minnesota SIDS Center. In response to the increase of infant deaths due to bedsharing, Title V worked closely with the Minnesota SIDS Center to provide Infant Sleep Safety Education folders and a brochure entitled "Safety Tips for Bedsharing with Your Baby". This brochure is distributed in large quantities to birthing hospitals throughout the state. Another compiled education folder brings together all the infant sleep safety messages including information on bedsharing, and are being distributed to local public health, tribal health, and community-based organization.

Substance abuse activities focus on the childbearing and prenatal population and include dissemination of a Women and Substance Use in the Childbearing Years Prevention Primer, a compendium of resources and a guide for client and community prevention educators and planners in a variety of practice settings, including such factors as domestic and sexual abuse and mental health issues and how they intersect with substance use/abuse. Work is underway on the CDC FAS Prevention grant with the purpose to increase Minnesota's capacity to integrate targeted and population based alcohol and contraception screening and behavior change interventions for women of childbearing age in select community settings; to reduce binge and prenatal drinking in women 18-44; to increase contraception use in women 18-44; to increase collection and use of data on women's drinking and contraceptive use; and to prevent and reduce FAS in targeted prenatal and preconceptional populations at risk for binge and prenatal drinking.
MDH oversees a state funded FAS prevention grant to a local advocacy organization for work on public education, screening and evaluation activities, and intervention programs. Prenatal smoking prevention and cessation activities include work with the Indigenous People's Task Force with the American Indian population, and work with a new state partnership sponsored and facilitated through the AMCHP, ACOG, PPA, and CDC technical assistance project.

Reproductive health The Family Planning Special Projects grants provide funding and technical assistance and support to the 41 community-based clinics and organizations that provide assessment, education and contraceptive methods services, and supports a family planning and STI hotline. A small Title X grant is administered to provide services to high risk teens in an inner city neighborhood in Minneapolis. Family Planning staff works with policy issues at the legislature and with implementation activities of the new state 1115 family planning waiver demonstration project. Abstinence grant activities include: community organization activities, use of a curriculum consistent with established principles for education, a media campaign, and state directed training and technical assistance for community-based projects.

Home visiting staff provide support to local public and Tribal health staff for either universally offered or targeted home visiting activities they undertake through the Local Public Health Grant. The state supports NCAST training for home visiting nurses and has increased a focus on maternal and infant mental health training and assessment. Home visiting staff provide training to utilize the home safety checklist for injury prevention.

Women's health --Women's Health Grant activities were focused on increasing the number of low-income women of color receiving primary and preventive health care services by identifying service gaps and eliminating barriers to care. Although this federal grant has now ended, the relationships developed through this grant continue to provide opportunities for collaboration. The Women's Health Team, convened by Title V staff, provides opportunity for women's health programs from across the

Department to work together so that systems of care serving women are improved. State staff work closely with the Community Center of Excellence at Northpoint Clinic in Minneapolis, and with the University of Minnesota Academic Center of Excellence in women's health, with whom a joint women's health website has been developed at www.healthymnwomen.org .

Infant health -- Title V staff are on the MDH Newborn Screening Advisory Committee and partner with the MDH laboratory on systems development, data and tracking linkages, and providing education, outreach, technical assistance, and materials development. Pediatric Nurse Practitioners and newborn screening follow-up staff facilitate enhanced care coordination and services for infants found by newborn bloodspot screening and their families. The MDH supports hospitals to provide newborn hearing screening and tracks results through integration with the state's Newborn Bloodspot Screening database, and is developing integration with vital statistics via a web-based system. MDH Early Hearing Detection and Intervention (EHDI) staff provide: technical assistance to hospitals; early intervention and follow-up; provider training; public information; and enhancement of a statewide family-to-family support network. Program activities are coordinated with Part C along with other MDH staff, faculty for the University of Minnesota Department of Otolaryngology, and members of the UNHS Advisory Committee. MDH staff works with the Departments of Human Services and Education to provide state leadership in early hearing detection and intervention, including tracking and reporting of outcomes. Sixteen regional EHDI teams continue to build capacity in their regions to better serve deaf-hard of hearing children and their families. The Follow-Along Program, which tracks development of children from birth to 3 years, is described within the Children with Special Health Needs population capacity.

POPULATION CAPACITY: CHILDREN AND ADOLESCENTS
Child and adolescent health screening This area of work supports accessible high quality health and developmental screening and health promotion for all children in the state. Goals of the program are adoption of healthy behaviors and assurance of early identification, treatment and remediation for those with health problems. Services include development of child health screening and health promotion guidelines, provision of training and technical consultation, and public education efforts. Specific programs supported include Child and Teen Checkups (Minnesota's EPSDT program) consultation and training under contract with the Department of Human Services, Nursing Child Assessment Satellite Training (NCAST) program, the scoliosis screening program, and maternal/infant mental health.

Birth Defects Information System (BDIS) Although the lead for this activity is in the Division of Environmental Health, Title V staff contribute significant expertise and time on the planning and the ongoing implementation of Minnesota's new Birth Defects Information System. The Follow-Along Program, which tracks development of children from birth to 3 years, is described within the Children with Special Health Needs population capacity.

School health / child care Specific attention is given to promotion of the health and safety of children in child care settings, school health (including hearing and vision screening), adolescent health, and children's mental health issues. Staff work closely with the Minnesota Children with Special Health Needs (MCSHN) Section as well as staff from related state agencies such as Minnesota Department of Education and the Department of Human Services. A report has been produced on a comprehensive system for the safe administration of medications in Minnesota schools, anchored by the development of statewide standards and guidelines and local district policies and procedures. This is available at http://www.health.state.mn.us/divs/fh/mch/schoolhealth.medadmin/ .

Adolescent Health Adolescent preventive health services are addressed through outreach and implementation of "Being, Belonging, Becoming: MN Adolescent Health Action Plan", which includes a focus on strengthening adolescent health care services and systems. Outreach includes technical assistance on use of a youth development framework for addressing adolescent health issues, information about best practices and health care guidelines, implementation of recommendations for action, and use of available resources to support effective strategies. Staff provides technical assistance to Eliminating Health Disparities Initiative grantees, local public health and other

community-based entities, and works closely with the Department of Education, other adolescent program areas within MDH, and the University of Minnesota Konopka Institute for Best Practice in Adolescent Health, Division of General Pediatrics and Adolescent Health, building skill and capacity of adolescent-focused work and programs across the state.

Early Childhood The MCH Bureau's State Early Childhood Comprehensive Systems Planning Grant is underway to develop a state plan for an integrated comprehensive early childhood screening system. The interagency partnerships between Title V, the Departments of Human Services and Education, and Minnesota Head Start have increased efforts to decrease duplication of preventive care and foster coordination between childhood programs that require preventive visits. Work through these relationships has provided joint regional screening workshops and the development of the Minnesota Child Health and Development Screening Quality Indicators: A Comprehensive Framework to Build and Evaluate Community Based Screening Systems.

POPULATION CAPACITY: CHILDREN WITH SPECIAL HEALTH NEEDS
Diagnostic clinics are a traditional component of the MCSHN program. These clinics provide quality medical and rehabilitation assessments for children with suspected or diagnosed special health needs, are staffed by a multi-disciplinary team or specialist with pediatric expertise, complement local health care, and are located in communities where such services are not in existence. Several of these clinics are contracted with institutional providers, including the International Diabetes Center and Gillette Specialty Health Care.

The MCSHN Community Systems and Development Team, with staff located in District Offices of the state, provides a wide variety of activities at the local, regional, and state levels with public and private agencies and families, including information and referral, child find and outreach, education and training, advocacy, technical consultation, newborn metabolic screening follow-up, and program/policy development.

Interagency Systems Development -- In addition to the Part C interagency activities, the MCSHN program participates in the state mandated Minnesota System of Interagency Coordination to support the development and implementation of a coordinated, multidisciplinary, interagency intervention services system for children ages birth through 21 with disabilities. This model, based on Part C, requires the development of an Individual Interagency Intervention Plan for all qualifying children, youth and young adults. Significant interagency planning and negotiating has been required between the Departments of Health, Human Services, Education, and Economic Security to support this multi-agency activity.

Follow-Along Program -- Title V MCSHN staff provide technical assistance and training to local public health agencies to support the Follow-Along Program in order to provide periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems and to ensure early identification, assistance and services. The software program for this activity, which uses the Ages and Stages Questionnaire as the screening tool, includes a social emotional component - the ASQ-SE. Special trainings have been targeted on this tool to the Somali population and to the Department of Human Services and local social services agencies on the use of the ASQ-SE to meet the requirements for mental health screening of children in the child welfare system.

Research and Policy Analysis -- The Research/Analysis and Policy work of MCSHN supports the development and enhancement of capacity to collect and analyze data for research and policy issues around children with special health needs and their families. It has engaged in a number of interagency collaborative activities to assess, direct and influence policy decisions that positively impact children with special health needs.

Medical Home -- Minnesota has adopted the medical home learning model promoted by the National Initiative for Children's Health Care Quality in its national medical home collaborative to advance the medical home concept -- particularly for children with special health needs. Eleven teams are in place throughout the state, each consisting of a pediatrician, a care coordinator, and two parents. MCSHN

is working closely with the state chapter of the AAP, has generated responsiveness to some productive media education and outreach, and will continue this work through it's newly awarded New Freedom Initiative grant.

Outreach / education / follow-up MCSHN staff work with staff of the MDH Division of Environmental Health, Birth Defects Information System staff to provide follow-up to families of all children confirmed as having neural tube defects, cleft-lip/palate or chromosomal anomalies. MCSHN staff provide health information related to the infant's condition, and refer the family to additional programs and services. MCSHN is gearing up to provide these same services for the 44 conditions that BDIS will be tracking.

MCSHN staff provide frequent trainings to families and providers about various public program services and how to access them through their "Taking the Maze Out of Funding" sessions. Through these trainings MCHSN provides updated information to numerous sectors and providers throughout the state regarding program and policy changes soon after they occur. The MCSHN Information and Assistance line provides information about and assistance in finding and accessing services and supports for children with special health needs and their families. Additionally, the web-based Central Directory of Early Childhood Services provides information about services and programs in both the web and hard copy format.

MCSHN disseminates condition-specific Guidelines of Care for Children with Special Health Care Needs which include Asthma, Cerebral Palsy, Cleft Lip and Palate, Feeding Young Children with Cleft Lip and Palate, Congenital Heart Disease, Cystic Fibrosis, Diabetes, Down Syndrome, Deaf and Hard of Hearing, Fetal Alcohol Syndrome and Fetal Alcohol Effect, Hemophilia, Juvenile Rheumatoid Arthritis, Muscular Dystrophy, Neurofibromatosis, PKU, Seizure Disorder, Sickle Cell Disease, and Spina Bifida.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM (SNP) /WOMEN, INFANT AND CHILDREN (WIC)
Also within the CFH Division, Title V staff work with SNP and WIC staff on many shared goals for healthy pregnant women and improved pregnancy outcomes, and healthy infants and young children. Closely aligned with Title V program activities, Special Supplemental Nutrition Programs has a total of 30.8 FTEs funded by the U.S. Department of Agriculture. This Section of the Division of Community and Family Health is comprised of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP). These two programs are designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. The populations eligible for these programs include: pregnant, breastfeeding, and postpartum women, infants, and children (up to the age of 5 for the WIC program and up to the age of 6 for the CSFP program). The CSFP program also serves the elderly population (age 62 and above). This Section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Indian tribal organizations to administer the WIC program; and to local food banks to administer the CSFP program. Participation rates have been rising steadily and currently, over 123,000 persons per month are served. Given that the clients of WIC are often clients of MCH, there is ongoing coordination between the two sections.

C. ORGANIZATIONAL STRUCTURE

State Department of Health The Minnesota Department of Health (MDH) is one of the major administrative agencies of state government. The Commissioner of Health is appointed by the governor with confirmation by the state senate, and serves at the pleasure of the governor. State law imposes upon the Commissioner the broad responsibility for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota. MDH Orgchart can be found at http://www.health.state.mn.us/divs/opa/orgchart.pdf

The Executive Office is organized into three Bureaus: Policy Quality and Compliance Bureau, Health

Protection Bureau, and Community and Family Health Promotion Bureau. Within the Bureau of Community and Family Health Promotion is the Division of Community and Family Health, (CFH), which is responsible for the administration of programs carried out by allotments under Title V.

The CFH Division is organized into the Director's Office and six sections: Office of Public Health Practice, Office of Rural Health and Primary Care, WIC/ Supplemental Nutrition Program Section, Maternal and Child Health Section, Minnesota Children with Special Health Needs Section, and Integrated Support for Cross Divisional Activities Section. The last three sections house the staff and resources where the primary Title V activities take place, although Title V staff work across the whole CFH Division -- as well as across the department. This new Division structure was created in August of 2004, when the Division of Family Health was combined with the Community Health Division. The former Director of the Division of Family Health at that time took on a new role of the Title V Coordinator, under which she reports directly to the Director of the Community and Family Health Division. The Community and Family Health Orgchart is found at:
http://www.health.state.mn.us/about/cfhorgchart.pdf

The CFH Director's Office houses 15 staff, 7 of which are at least partially funded by the MCHBG: 4 grant and administrative staff, an IT staff, a genetics position, and the Title V Coordinator.

The mission of the MCH Section is to provide statewide leadership and public health information essential for promoting, improving or maintaining the health and well-being of women, children and families throughout Minnesota. The structure to support this work consists of 3 work units: Newborn and Child Health Unit, Family and Women's Health Unit, and the Support Unit. The Family Planning staff report directly to the MCH Section Manager. This Section has 10.4 FTEs funded by the MCHBG; 13 FTEs funded by targeted state funds; approximately 8 FTEs funded by various federal grant programs; and other positions funded through a mix of sources for a current total of 34.5 FTEs.

The Minnesota Children with Special Health Needs (MCSHN) Section is the Title V CSHN component. As such, it seeks to improve the quality of life for children with special health needs and their families through the promotion of the optimal health, well being, respect and dignity of children and youth with special health needs and their families. MCSHN provides statewide support to achieve: early identification, diagnosis and treatment, family centered services and systems of care, access to health care and related services, community outreach and networking, and collection and dissemination of information and data. MCSHN is structured into the Research and Policy Unit, and the Community and Systems Development Unit, which has 6 staff housed in District Offices across Minnesota. MCSHN has 19.6 FTEs funded by the MCHBG, 4.3 FTEs funded through interagency agreements with the Department of Education, 2 FTEs funded by federal grants, and approximately 1.5 state funded FTEs for a total of 27 FTEs.

The Integrated Support for Cross Divisional Activities Section is responsible for supporting and strengthening cross-divisional activities which include: broad internal and external communication; how the Division uses data to monitor and evaluate programs and the health status of mothers and children, including children with special health care needs; and work on emerging issues that require Division --wide input and monitoring as well as a special focus on adolescent and school health. This Section has 5.6 FTEs funded by MCH Block Grant; .4 funded by Preventive Block Grant; 1.0 FTE funded by SSDI; .5 FTE funded by the CDC FAS Grant; .25 FTE funded by Medical Assistance; and other partial FTEs funded by a mix of state and federal funds, for a total of 8.3 FTEs.

As required, organizational charts are available on file in the Community and Family Health Office.

Local Public Health More detail regarding the structure, function, and Title V relationships with local public health are described in Section B, Agency Capacity. In 2004, the State Community Health Services Advisory Committee appointed a work group to identify essential local public health activities that should be available in all parts of the state. This Essential Local Public Health Activities Framework is intended to: define a set of local public health activities that Minnesotans can count on no matter where in the state they live; recommend a statewide plan for implementation; provide a

consistent framework for describing local public health to state and local policy makers and the public; and provide a basis for ongoing measurement, accountability and quality improvement related to the implementation or assurance of essential local activities. Title V staff are actively involved in the ongoing planning for these significant revisions to Minnesota's public health system involving the creation of a set of Essential Local Public Health Activities, Statewide Outcomes, and an Outcome Reporting System. The website address http://www.health.state.mn.us/cfh/na provides a schematic of Minnesota's Local Public Health Improvement Process. Title V staff have been and remain actively involved in the ongoing planning for these significant revisions to Minnesota's public health system involving the creation of a set of Essential Local Public Health Activities, Statewide Outcomes, and an Outcome Reporting System. This has provided a good opportunity to insure that MCH related program areas were incorporated into this framework of essential services, statewide outcomes, and development of the reporting system. Title V staff continue a high level of involvement in the ongoing planning, and the training and guidance to local public health as these significant system changes are implemented. More information on this activity is available at http://www.health.state.mn.us/phsystem.html#essential.

D. OTHER MCH CAPACITY

See previous Section C Organizational Structure for the location and numbers of Title V staff.

SENIOR MANAGEMENT BIOGRAPHICAL SKETCHES
The state MCH Director, the Director of the Community and Family Health Division, has served in that capacity since August of 2004. Prior to that time she was the Director of the Community Health Division for 4 years, and has held a number of positions throughout the Health Department including Tobacco Endowment Director, Manager of Environmental Health Services and Manager of Acute Disease Prevention Services. She has worked at the Department for over 20 years, prior to which she worked in local public health agencies in two different Minnesota counties. She has a Masters in Public Health Nursing from the University of Minnesota, and served a term as president of the Minnesota Public Health Association.

The state CSHN Director, the MCSHN Section Manager, has a Master's degree in hospital and health care administration and has 21 years of experience in health planning, five in hospital corporation activities, 9 in maternal and child health and 7 in CSHCN.

The MCH Section Manager The Section Manager has worked in public health for 25 years in MCH. Much of her experience has focused on providing services to high risk parents including pregnant and parenting teens. After 20 years of providing MCH services at the local level she accepted a position at the Minnesota Department of Health working in the Reproductive Health Unit. Work in this unit included provision of technical assistance for a MCH programs including MN ENABL (Education Now and Babies Later), TANF home visiting, family planning, infant mortality reduction and women's health. In February 2004 she accepted the position of Maternal Child Health Section Manager at the Minnesota Department of Health.

The Title V Coordinator was previously the state MCH Director for 5 years, and has over 20 years of MCH experience -- both at the state and local level. She is an occupational therapist by training and has a MPH in the MCH area from the University of Minnesota.

PARENT ROLES
The MCSHN program has, since FY 2000, had a Family Consultant Advisory Group. Consisting of up to eight parents, this group has brought to MCSHN policy discussions the voice of parents and their children. Parents demonstrated significant leadership and advocacy skills in service system or policy development at the state or local level prior to his/her selection, and most had been through previous advocacy and or leadership programs. Many parents were either graduates of Parents in Policymaking (a program of the Governor's Council on Developmental Disabilities) or the Minnesota Early Learning Design {MELD} Special Parent trainings. The Family Voices representative in Minnesota has provided administrative oversight to the Advisory Group.

The Advisory Group has been meeting to review the six core outcomes of the Bureau's ten-year action plan and is framing specific actions for the state's work plan, and has also focused on health disparities documented by the MCSHN program through analysis of the Minnesota Student Survey. Discussions have also been underway regarding important transition issues of responsibilities of local public health agencies brought about by the 2003 legislative changes in the funding of local public health due to significant budget deficits.
MCSHN's Medical Home project utilizes the Breakthrough Series collaborative model, consisting of eleven medical home teams throughout the state. Each team includes two parents. In addition, Minnesota's Family Voices representative is actively involved in the medical home activities to bring in broader family perspectives. This medical home collaboration with parents and Family Voices will continue as the New Freedom Initiative for Integrated Community Systems of CSHCNs works to mobilize policy and practice partners among physicians and families. These activities will include a parent summit to identify common themes and concerns and will utilitze an on-going parent steering work group.

Several MCSHN staff are also parents with one or more children who have a special health care need. The roles these parents perform and the positions they occupy in the program include supervisory, policy and program planning, and technical consultation for statewide programs.

E. STATE AGENCY COORDINATION

Collaboration and coordination is a fundamental value and strategy for the work of Title V. It is essential to the accomplishment of our goals. Many of the earlier sections of this report as well as the Performance Measure narratives describe multiple partnerships between Title V, other MDH program areas, other state agencies, community-based entities, and local public health. These relationships are both long-standing, and also include some exciting new opportunities. Some of these are formal with MOUs and MOAs in place, and many are less formal.

Intra-Agency Coordination
Office of Rural Health and Primary Care Minnesota's Title V and Primary Care Office (PCO) programs support each other's mission and the goals and objectives of their respective SSDI and Cooperative Agreement (CA) grants. The mission of the PCO is to improve access to preventive and primary care services for underserved Minnesotans. The Title V program works, in part, to further efforts of organizations that deliver health services to mothers and children and to provide leadership for statewide maternal and child health issues. Both programs promote the development of community-based, family-centered, comprehensive, coordinated, and culturally competent systems of services as a priority. The MCH Mental Health Coordinator is working closely with the Rural Health Advisory Committee on their priority for the year -- mental health issues in rural Minnesota. Focus areas include resources and provider capacity, and system issues rural Minnesota in the area of mental health.

The Office of Minority and Multi-Cultural Health relies on Title V staff for specific program area expertise for the Eliminating Health Disparities grantees, and Title V staff likewise rely on OMMH staff for access, guidance and assistance in their work with ethnic/cultural activities and groups. These partnerships have produced several joint trainings, conferences and other projects. Title V continues its leadership and commitment to support work with American Indians in Minnesota. The Title V Coordinator and other key Title V staff work closely with the MDH Tribal Health Liaison on planning for and attending quarterly Tribal Health Directors meetings, supporting internal department wide meetings on American Indian health; traveling together on site visits to reservations; and providing information, resources and support for the American Indian Health Grants made directly to Tribes in Minnesota.

Tobacco Prevention and Control Program (TP&C) and Title V MCH Section staff continue to work together to address tobacco prevention among children and families in Minnesota, with a growing

focus on smoking cessation for pregnant women. Staff from both sections partner in the Robert Wood Johnson/ ACOG/Planned Parenthood project.

Center for Health Statistics (CHS) staff work on numerous projects with Title V staff, including data analysis, data and systems planning, training and presentations, and consultation. While the Title V Coordinator is the Principal Investigator for PRAMS in Minnesota, the day-to-day administration takes place in CHS, and the PRAMS steering committee includes staff from both Divisions. Joint activities are underway matching birth certificate information, newborn screening information, and the upcoming Birth Defects Information System (BDIS).

The Division of Environmental Health houses several program areas on which Title V has been and continues to be priority partners areas, including the BDIS, lead programs, and work on Children's Environmental Health. The state Public Health Laboratory and Title V staff work in tandem on the newborn bloodspot and hearing screening programs in planning, administration, education and training, monitoring, evaluation and follow-up. Routine newborn screening meetings are held with management staff from both Divisions.

Ongoing relationships exist between Title V staff and several other program areas in MDH that generally enhance the work of both partners and frequently produce special short-term projects or activities. These areas include the immunization program, injury prevention, nutrition (outside of WIC), sexual violence prevention, STI / HIV prevention, and as described elsewhere, and the women's health team, convened and supported by Title V but drawing it's members from across the department.

Inter-agency Coordination
Department of Human Services (DHS): The Title V program and the Department of Human Services (the state's designated Title XIX and Title XXI agency) have a long history of collaboration framed by a formal interagency agreement. See Title V-Title XIX Interagency Memorandum of Understanding . Current collaborative efforts include the Family Service Collaboratives and the Children's Mental Health Collaboratives. DHS is represented on the MCH Advisory Task Force in an Ex-Officio status and Title V participates on the Medicaid Advisory Task Force. Numerous other activities are noted throughout this application. Formal contracts exist which provide DHS funding for staff in the Title V program relative to EPSDT, and services to deaf, hard of hearing, and deaf-blind individuals. Management and Executive Office staff of MDH and DHS meet on a quarterly basis to discuss issues of mutual interest and concern. Minnesota has several early childhood programs administered by DHS and representatives of these programs were involved in the MECCS grant (Minnesota's State Early Childhood Comprehensive Statewide Systems grant). Title V staff are important partners with DHS involved in the ABCD II grant, aimed at strengthening services and systems that support the healthy mental development of young children.

Department of Education The Title V program and the Department of Education (DOE) collaborate on many projects and programs: Family Service and Children's Mental Health Collaboratives, Part C, Early Childhood Screening, pregnancy prevention and abstinence education programs, Fitness Fever, Minnesota Healthy Beginnings, service coordination (for ages 3-21), third party billing, a children's advocate group, and a grant advisory board regarding children with special health care needs and child care. There is active collaboration between DOE and MDH on the Minnesota Student Survey, including Title V staff. In State Fiscal Year 2004, MCSHN expanded its Interagency Agreement with MDE to include Part B as well as Part C (of IDEA) responsibilities.

The DOE is the lead agency in Minnesota for the Early Childhood Intervention Program (Part C); a joint initiative of three state agencies: (Health; Human Services; and Education and local IEICs (Interagency Early Intervention Committees). Through an interagency agreement, the Department of Health receives funding for specific activities and staff within the Minnesota Children with Special Health Needs (MCSHN) Section. MCSHN provides time to the Part C project on the mandated State Agency Committee (SAC) and the Governor appointed Interagency Coordinating Council (ICC). The Department of Health's Part C team provides outreach, information, training, and technical assistance

on health related early childhood topics and issues to families; state, regional, and local health, education, and human service agencies; public and private providers and IEICs (Interagency Early Intervention Committees). The team has primary lead for public awareness/child find; ongoing technical support of the Follow Along Program (tracking system for identifying children at-risk); a statewide information and assistance line (central directory requirement); establishing and maintaining an interagency data system; and providing training and technical assistance on managed care issues, health benefits coordination, and outreach to health care providers on Minnesota's early childhood intervention system.

Department of Corrections: The Department of Corrections participates with MDH, DHS, and Minnesota Department of Education on children's mental health issues in the state. This relationship has been long standing and children's mental health issues provide avenues and linkages to address children's mental health issues in juvenile correction centers. Title V staff also collaborate with the Minnesota Department of Corrections on adolescent health issues through the Interagency Adolescent Female Subcommittee (IAFS). This is a subcommittee of the Department of Correction's Advisory Task Force for Female Offenders in Corrections. The MCH Adolescent Health Coordinator is a member of the IAFS and provides the adolescent health perspective to its work, assuring gender-specific programming for girls in corrections.

Children's Mental Health Collaboratives: The primary focus for children's mental health in Minnesota is the development of a community-based, unified system of services for the child and family. The Comprehensive Children's Mental Health (CCMH) Act requires that counties provide a specified array of mental health services to children. The CCMH Act establishes guidelines for development of Children's Mental Health Collaboratives including integration of funds in order to use existing resources more efficiently, minimize cost shifting and provide incentives for early identification and intervention. This focus on early identification and intervention gives increased importance to public health agency efforts and expands opportunities for coordination with other services. Local partnerships with social services, corrections, and education agencies create integrated systems that improve services to children with mental health problems and provide services for their families.

Family Service Collaboratives: Family services collaboratives were initiated in 1993 by the Minnesota legislature which mandated public health's involvement, recognizing the vital role public health plays in assessing and addressing the health of all mothers and children in communities and the state. Included in this initiative were collaboration grants to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hoped to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. Recognizing that no single funding source alone is responsible for changing outcomes, a set of statewide core outcomes was distilled from the collaboratives' efforts. Promoted across systems in 1998, this list has been included in the work of the Family Support Minnesota formerly the STATES Initiative, the KIDS Data Project, and Minnesota Healthy Beginnings, among others. Many of these outcomes and their indicators align with the federal/state MCH performance measures; and many others offer future directions for development of measurement tools, in particular, those with the promotional perspectives of family support.

Coordinated System for Children with Disabilities Aged Three to 21 -- involving multiple state agencies: State law mandates a coordinated interagency system for children from three to 21 with disabilities, as defined by IDEA. Staff from MDH have been actively involved with an 18 member State Interagency Committee made up of seven state agencies and other participants for oversight of this planning, as well as numerous workgroups creating the guidance for this system at both the state and community level.

University of Minnesota: Collaboration between the Title V agency and the University of Minnesota School of Public Health continues on various research, evaluation and training projects. The MCH program within the School of Public Health holds an Ex-Officio position on the Department's Maternal

and Child Health Advisory Task Force. The Department's Title V program collaborates with the school's MCH program community education activities including presenting at its annual summer Institute. A number of MPH students have their internships in the Division of Community and Family Health, and several Title V program staff are graduates of the program. Faculty from the University have provided training and technical assistance to Title V staff through informal communications as well as some sessions--particularly as part of the building capacity activities underway over the past two years.

The MCH Adolescent Health Program collaborates extensively with the University of Minnesota Konopka Institute for Best Practices in Adolescent Health, Division of General Pediatrics and Adolescent Health. This partnership focuses on building the capacity and skill of adolescent-focused programs across the state. MCH Reproductive Health staff collaborate with the National Teen Pregnancy Prevention staff at the University of Minnesota on numerous projects including the implementation of the state teen pregnancy prevention and parenting plan.

The MCSHN program serves as mentors for each of the students in the University of Minnesota School of Nursing program emphasizing CSHCN. In addition, MCSHN, the School of Public Health and the Center for Urban and Regional Advancement (CURA) of the Humphrey Institute (University) worked together to evaluate MCSHN Developmental Behavior Clinics. The University of Minnesota receiving status as an Academic Center of Excellence in Women's Health has brought opportunities for enhanced relationship and shared activities. This dual partnership has also extended to include the Community Center of Excellence at an urban Minneapolis clinic. MCH epidemiology staff from the University were helpful in planning, recruiting, and hiring for a new MCH Epidemiologist position at MDH.

F. HEALTH SYSTEMS CAPACITY INDICATORS

See Forms 17, 18, and 19 for Health Systems Capacity Indicators tracking and data.

Review of the data for this year indicates some changes for Minnesota in the Health Systems Capacity Indicators. There have been some improvements for screening of children. HSCI#2 shows that Medicaid enrollees less than one year during the reporting year who received at least one initial periodic screen increased from 77.4 percent to 85.7 percent. HSCI#5 as well shows an increase in EPSDT eligible children aged 6 through 9 years who received any dental services during the year from 45.9 percent to 46.7 percent. A slight increase but positive nonetheless, particularly within this time of decreasing resources. Likewise, for pregnant women receiving prenatal care visits at greater or equal to 80 percent on the Kotelchuck Index (HSCI#4) the percent increased from 77.1 to 77.5 percent of women with a live birth, although we know there are large disparities in this statewide rate for populations of color and American Indian women.

While there were some other changes made in public health care programs, as outlined in the State Overview section of this report, the eligibility remained the same for children and women in Medicaid and MinnesotaCare, with the exception of the MA income eligibility for children from 2 to 18 years, decreased from 170 percent FPL to 150 percent FPL (HSCI#6). Additionally, the automatic eligibility for infants born to an MA mom was reduced from 2 years to one year, and children's eligibility for MinnesotaCare will have to be renewed every 6 months as opposed to annually.

The rate of children hospitalized for asthma per 10,000 children less than five years increased from 25.9 to 28.4 (HSCI#1). This suggests that a meeting with our MDH colleagues in the asthma program is in order to discern what this increase is about, what might be done about it, and see that this

doesn't become a trend.

HSCI#8 related to the percent of SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHN program is somewhat moot in Minnesota. All of these children and youth are eligible for Medicaid, which provides a full package of services, thereby negating the role of MCSHN to provide services. Therefore, this number is always zero. The situation is similar with HSCI#3 in that Minnesota does not have a SCHIP program.

Data linkages and registries
There were no changes in any of these measures. However, in way of qualitative comments, Title V staff remain actively involved in the Minnesota Student Survey -- both in the planning and follow-up use of the information, and in the planning and implementation of the newly developing Birth Defects Information System. The newly formed data/epi team as noted earlier in this report, is providing increased capacity which will enhance our ability to make progress on data linkages, within the context of Minnesota's data privacy laws and issues.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The state performance measures reported on in this section A are the closing out of those measures from the last 5 year reporting cycle. New state priorities and performance measures have been developed out of the 2005 Needs Assessment process and information on those is provided in section B below.

The following performance measures either met or exceeded the target, based on the most recent data available:
· NPM1 -- newborn blood spot screening
· NPM8 -- teen pregnancy rates
· SPM1 -- enrollment of birth to three year olds in the Follow-Along screening program
· SPM4 -- child abuse and neglect rates
· SPM6 -- alcohol, tobacco and drug use during pregnancy
· SPM9 -- out of home placement for CSHN
· SPM10 -- CSHN with an Individualized Interagency Intervention Plan
· OM1 -- infant mortality rate
· OM2 -- black to white ratio of infant mortality
· OM3 -- neonatal mortality rate

Improvement was made on the following performance measures, although the target was not met:
· NPM7 -- immunization rates
· NPM9 -- third graders with a dental sealant on at least one molar
· NPM10 -- motor vehicle accidents of children 14 years or younger
· NPM12 -- newborn hearing screening
· NPM15 -- VLBW
· NPM18 --infants born to mothers receiving prenatal care in first trimester
· SPM2 -- insured children receiving standard comprehensive health visits
· SPM3 -- injury incidence for all MCH populations
· OM4 -- postneonatal mortality rates
· OM5 -- perinatal mortality rates
· OM6 -- child death rates

Measures were maintained, but the target was not met on these following measures:
· NPM13 -- children without health insurance
· SPM5 -- rates of unintended pregnancies

Measures that worsened and will require further focused effort:
· NPM11 -- breastfeeding at hospital discharge
· NPM16 -- youth suicide
· NPM14 -- Medicaid-eligible children that received a service
· NPM17 -- VLBW births at high-risk facilities

These following measures are based on the SLAITS for children with special health needs, so have no new data available:
· NPM2 -- families partnering in decision making at all levels
· NPM3 -- medical home
· NPM4 -- adequate public and/or private insurance
· NPM5 -- services being organized for easy use
· NPM6 - youth receiving services necessary for transition

B. STATE PRIORITIES

This section describes the relationships between the new state priorities from the recently completed

2005 needs assessment and several measures: the national performance and outcome measures, Health System Capacity Indicators, Health Status Indicators, Minnesota's state priorities from the previous 5 year cycle, and some of the statewide outcomes for Minnesota's developing Local Public Health Grant (LPHG) activities. These LPHG statewide outcome measures are newly developed and work is currently underway to establish the reporting system through which these measures will be reported by local public health agencies to MDH. These priorities are in no particular order.

Priority 1 -- Improve early identification of and intervention for CYSHCN -- birth to three years. Early identification, screening and referral systems identify children's strengths as well as their needs. These systems can maximize healthy child development and minimize adverse health, social and emotional incidents. Universal screening of all children, birth to age three--regardless of perceived risk factors--promotes thorough identification of those with special health care needs and subsequent provision of intervention services to children who are eligible under Part C of Individuals with Disabilities Education Act (IDEA). This priority is related to NPM 1 - newborn screening, NPM3 - medical home, NPM5 -- services being organized for easy use, NPM12 -- newborn hearing screening, HSCI #2 & 3 children on Medicaid and MinnesotaCare who received at least one initial or periodic screening, and the new statewide outcome for essential local public health activity #19 -- Increase the percentage of children ages birth-3 who are screened for developmental and social emotional issues every 4-6 months. This state priority is essentially the same as the priority from the last 5 year cycle to assure early identification and intervention for young children.

Priority 2 -- Assure that children and adolescents receive comprehensive health care, including well child care, immunizations, and dental health care. Well-child care reduces long-term costs by encompassing a variety of health promoting/disease preventing services and by providing opportunities to detect and treat health conditions early. Within the Medicaid population, as in the entire population of children and adolescents in Minnesota, incidence of chronic disease is growing - particularly childhood obesity, diabetes, asthma, mental health disorders, and injuries. Prevention and health education services, and early detection and treatment may assist in reversing this trend. This state priority is related to NPM 1 -- newborn screening, NPM 4 -- adequate insurance, NPM 7 -- immunizations, NPM 9 -- 3rd graders with protective sealant on molar, NPM 12 -- newborn hearing screening, NPM 13 -- children with insurance, NPM 14 -- MA eligible children receiving a service paid by MA, OM6 -- child death rate, HSC#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, HSCI#6 -- FPL eligibility for MA, HSCI #7 -- EPSDT children receiving dental service, and the new statewide outcome for essential local public health activity #24 increase the percentage of 2 year olds that have been age appropriately immunized.

Priority 3 -- Prevent teen pregnancy and sexually transmitted infections. Teen pregnancy has been steadily decreasing in recent years but has reached a plateau in Minnesota, while STIs have continued to increase among females and among adolescents and young adults, with significant disparities among some racial/ethnic groups. If undetected and untreated, these STIs can lead to other severe health issues and possibly infertility. This priority is related to NPM8 -- teen birth rate, HSI#05a Chlamydia rate for females 15 to 19, and the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 4 -- Prevent child abuse and neglect. Child maltreatment is among the most prevalent and far-reaching forms of violence in Minnesota. All four maltreatment types (neglect, physical abuse, sexual abuse, mental/emotional injury) are represented here. Further, child and adolescent maltreatment often precedes adult violence and substance misuse/addiction as the abused child grows older. This is a repeated state priority from the last 5 year cycle and is related to the new statewide outcome for essential local public health activity #22 - reduce the rate of maltreatment and sexual abuse of children ages birth to 17 years olds.

Priority 5 -- Promote planned pregnancies and child spacing. Pregnancies which are intended and/or planned will likely result in improved health outcomes, lower occurrence of perinatal/postpartum depression, fewer abortions, decreased child maltreatment and other negative outcomes for pregnant women, infants and children. Access to family planning is critical to achieve this goal. This priority is a

repeat from the last 5 year cycle and is related to NPM8 - teen birth rates, NPM 18 - early prenatal care, HSCI #4 --women meeting Kotelchuck Index, HSCI#5 Medicaid and non- Medicaid comparisons on the Kotelchuck Index, HSI#1 -- low birth weight births, and is related to the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 6 -- Assure early and adequate prenatal care. Minnesota records approximately 70,000 births annually with an estimated 1.1 million women of childbearing age. The percent of women who met the Kotelchuck Index has been increasing slowly and for 2003 is at 77.5 percent. Women with late or no prenatal care are unlikely to receive the services that promote early identification of problems and the healthiest birth outcome possible. There are continuing racial/cultural and economic disparities in rates of adequate prenatal care. This priority is related to several other measures of prenatal care -- NPM18, HSC#4, HSC#5; to 5 of the 6 outcome measures related to infant mortality, as well as HSC#05b re: infant mortality for MA and non-MA; to birth weights -- NPM 15, HSC#5, HSI#1, HSI#2; and is related to the new statewide outcome for essential local public health activity #29 early and adequate prenatal care.

Priority 7 -- Promote mental health for children and adolescents, including suicide prevention. Mental disorders were the sixth leading cause of emergency room visits among 5-19 year olds in Minnesota and the leading cause of hospitalization for 5-14 year olds in 2001. From 1998-2002 suicide was the third and second leading cause of death for 10-14 year olds and 15-19 year olds, respectively. Disparities exist within some racial and cultural populations. This priority is related to NPM 16 -- suicide deaths among youth ages 15-19, and to several of the new statewide outcome for essential local public health activities: #15 -- reduce the rates of suicide; #16 -- reduce the rate of hospital-treated self-inflicted injuries; #17 -- increase the screening for mental health needs for children, adolescents, and children with special health needs; #19 -- increase the percentage of children birth to 3 who are screened for mental health and social emotional issues every 4 to 6 months.

Priority 8 -- Eliminate racial and ethnic health disparities impacting mothers and infants. There are substantial health disparities for pregnant women, mothers and infants in Minnesota. Many of these disparities are masked by the excellent health outcomes and very high proportion of our white population. Health disparities exist in birth weight outcomes, infant mortality, neonatal and perinatal mortality, maternal mortality, insurance status, adequacy of prenatal care, and numerous social and economic conditions that affect health. This priority is related to OM #2 -- ratio of black to white infant mortality, HSI#08 -- deaths of infants and children by racial subgroup, and to the new statewide outcome for essential local public health activity #1 increase the number of community health boards that assess disparities and social conditions that underlie health and address them in their action plans.

Priority 9 -- Improve access to care of children and youth with special health needs (including medical home, specialty care and services, oral health and that services are organized for easy use). CYSHCN often have multiple disabilities and service needs cutting across several areas. Thus it is critical to have access to a variety of specialized services, as well as oral health care. Of those children in Minnesota who needed specialty services in 2001, nearly 23,000 (14%) had one or more unmet needs, placing MN last in the Upper Midwest in meeting specialized service needs for CYSHCN. This priority is related to NPM 3 -- medical home, NPM 4 -- adequate insurance, NPM 5 -- families reporting community-based service systems are organized so they can use them easily, NPM 6 -- services to support transition, NPM 9 -- 3rd graders with sealant on molar, NPM 13 -- children without health insurance, NPM 14 -- MA children receiving a service, HSI#9 -- state health program enrollment, HSCI#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, , HSCI#6 -- FPL eligibility for MA, HSCI#7 -- EPSDT children receiving dental service, HSCI#8 SSI youth connected to CSHN services, and to the new statewide outcomes for essential local public health activities #30 -- families partnering in decision-making, #31 - families reporting organized services systems, and #32 -- increase clients enrolled in health insurance programs.

Priority 10 -- Improve access to comprehensive mental health screening, evaluation, and treatment of CYSHCN. Anxiety, depression (including suicidal thoughts) and other mental disorders often occur among CYSHCN. In addition, CYSHCN are highly vulnerable to maltreatment, including neglect and physical, sexual, and mental abuse. Early identification of and intervention for mental health issues are critical in this population. Having health insurance can influence access to mental health services thereby creating a relationship between this priority and all the insurance measures: NPM 4 -- CYSHCN with adequate insurance, NPM 13 -- children without insurance, HSCI#6 -- FPL eligibility for MA, and HSI#9 -- state program enrollment. This priority also relates to NPM 16 -- youth suicide deaths, HSI#3 -- deaths due to injury, HSI#4 -- nonfatal injury, HSCI#2 -- MA children receiving a screening, and to the new statewide outcomes for essential local public health activities #15 suicide rates, #16 hospital treated self-inflicted injuries, #17 increase the screening for mental health needs for adolescents, children with special health needs and pregnant and postpartum women, and #32 -- increase the number of clients who are enrolled in health insurance programs.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator		98.5	99.7	100.0	
Numerator		65618	67839	2593	
Denominator		66617	68034	2593	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2003

The sharp reduction in the numerator and denominator is due to a change in the way this indicator is reported. Instead of the number of newborns screened the denominator now represents the number of newborns screened and presumed positive for at least one condition. The numerator represents the number of presumptive positives who received appropriate follow-up.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving all newborns is related to the state priorities: "Increase percent of children whose disability is identified early". (Program and Resource Allocation: Direct Health Care; Enabling Services; Population-based services; Infrastructure Building).

The percentage of newborns screened has remained stable at an estimated 99% since 1996. The newborn screening fee remained $61.00 per infant. Pursuant to the revised 2003 state statute, the Minnesota Department of Health Newborn Screening Advisory Committee was formalized and met in April, 2004. All newborns must be screened for phenylketonuria (PKU), congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, and hemoglobinopathies. The Newborn Metabolic Screening Program tests samples taken from newborns, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This program is operated as a partnership of Family Health Division and the Public Health Laboratory Division.

Major activities which began in 2004 include 1) adding biotinidase deficiency to the newborn screening mandated panel. Related activities encompassed obtaining approval, developing laboratory methods and expertise, creating educational materials, providing outreach to the community, involving the pediatric metabolic specialists to build capacity, develop clinical response plans and treatment protocols. 2) Finalizing a contract with Mayo Medical Laboratories for transfer of the MS/MS component of the screening panel (amino acid, organic acid, fatty acid oxidation disorders) from MDH to Mayo in addition to a second tier test for congenital adrenal hyperplasia was a major initiative. New procedures and methods of communication were implemented. 3) Beginning UPS specimen pick up was implemented statewide. 4) Education, technical assistance and outreach to approximately 80 hospitals accounting for 90% of the births in Minnesota was accomplished through consultative site visits by genetic counselors and follow up staff.

The newborn screening fee increase and support through the MCHB/HRSA cooperative agreement provided for program and data coordination, an increase in administrative support, IT, and follow up program staff resulting in improved notification and tracking for abnormal newborn screens, development of provider and consumer education materials and increased collaboration between blood spot and hearing programs within the Minnesota Department of Health.

A pediatric nurse practitioner and newborn screening follow up staff facilitated enhanced care coordination and services for infants found by newborn bloodspot screening and hearing screening and their families. Resources available for families included a medical home, pediatric specialists, genetic counseling, high-risk public health follow up programs, early education, WIC, and financial programs such as Medical Assistance, Minnesota Care and others.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the expanded blood spot testing as recommended by the State NBS Advisory Committee	X		X	
2. Expand follow-up activities to identified infants & their families for all additional tests	X	X	X	X
3. Refine lab procedures for reducing false positive/negative test results			X	X
4. Expand educational materials & activities to include all disorders identified by MS/MS screening and early hearing detection and intervention		X	X	
5. Refine integrating data collection, infant follow-up & tracking with hearing screening program				X

6. Link identified infants & their families to community resources & a medical home	X	X		X
7. Develop systems to help primary care physicians care for children with rare disorders				X
8. Continue active participation on the Newborn Screening Advisory Committee				X
9. Initiate linking blood spot and hearing data with birth/death certificates			X	X
10. Develop and implement an evaluation plan.				X

b. Current Activities

1) Screening for biotinidase deficiency began for all infants in Minnesota; ongoing evaluation of the process and implementation continues for this disorder. 2) Now that the Mayo Medical Laboratory contract is in place to screen amino acid, organic acid, and fatty acid oxidation disorders cases are reviewed weekly between Mayo, University of Minnesota Pediatric Metabolic Clinic staff and Minnesota Department of Health newborn screening lab and follow up staff in order to assure optimal diagnosis, treatment and referral for infants and their families. 3) The realization of a long time goal for data linkage between birth/death records and newborn screening has been made possible in large part because of efforts related to one of the priorities in the MCHB/HRSA cooperative agreement. Policies and procedures to locate and follow up on infants who "missed" having a newborn screen are being developed. 4) Infants with endocrine, hemoglobinopathies, metabolic and hearing disorders found on newborn screening and their families are offered care coordination and referral to a variety of financial, support, educational, community resources. Methods to integrate coordination activities into the newborn screening system more fully and to evaluate the impact of these activities are being developed. 5) Staff are participating with the University of Minnesota pediatric endocrine department in the development of a new multidisciplinary clinic to serve children who have congenital adrenal hyperplasia and their families. 6) Minnesota is developing a new newborn screening brochure.

The Minnesota MCH Bureau State Genetics Implementation Grant, supports enhancing, expanding and integrating current activities around both newborn blood spot and hearing screening programs. The state also has a newborn screening data and program integration grant from HRSA/MCHB.

c. Plan for the Coming Year

An initiative is underway to add Cystic Fibrosis to the Minnesota newborn screening blood spot panel. Building capacity to accomplish this will be a focus of activity. Other areas of emphasis will be: 1) improving repeat tracking, improving documentation in the data base, and linking birth certificates with newborn screening. 2) Strengthening the education component with the medical home provider when presumptive positives are identified; 3) expanding outreach, education and technical assistance activities related to newborn screening especially hospital neonatal intensive care units and prenatal providers 4) exploring an expansion of the Mayo partnership in areas of screening, clinical protocols and research applications; 5) improving hemoglobinopathy communications and support; 6) developing screening brochures in multiple languages; 7) revising the "bloodspot card" to meet program needs; 8) Consider the role of the newborn screening program in trait counseling for hemoglobinopathies and cystic fibrosis.

Support from the data and program integration grant, will enhance efforts to improve systems and data linkages among programs. The Program will continue to strengthen relationships with statewide population based programs such as MCSHN, Universal Hearing Screening Program, high risk Follow Up Programs, and early education. The Newborn Screening Advisory Committee, which includes Title V staff, will maintain a key role in identifying future program directions and priorities.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				59.1	59.1
Annual Indicator			59.1	59.1	
Numerator				97156	
Denominator				164329	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	63	63	63	63

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serves children with special health care needs and is related to the state priority: "Promote family support and healthy community conditions" and " Promote healthy parenting/family development." (Program and Resource Allocation: Population-based Services and Infrastructure Building).

There were four areas of either direct parental involvement or support for parental involvement during the report year. The MCSHN program continued using a small group of parents as program advisors through a contract with PACER Center, Inc. The input of this small group is sought on all major policy and organizational issues faced by the MCSHN program. The second area includes the formation of medical home teams in January-February of 2004. Each team is comprised of a pediatrician, care coordinator and two parents. The medical home teams met twice during the report year and once during the current year using the collaborative medical home model advanced by NICHQ (see NPM#3 for more detail). The third area entails

the activities spent on the MnSIC-III-P process (see NPM#5). The state CSHCN director is a member of the policy-making body governing this process and has continued to advocate for the inclusion of parents (which would require legislative action) on this body. The fourth area includes the Family Voices presence in the state. The representative of Family Voices became a member of the statewide Maternal and Child Health Advisory Task Force at the end of the report year. This task force is a standing task force appointed by the commissioner of health to advise the commissioner on all maternal and child health issues including issues affecting CSHCN. The MCSHN program also contracts with PACER Center and its Family and Health Advocacy Center for consultation and education for the parent members of the medical home teams.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update MAZE training content to reflect changes made by the 2005 legislature				X
2. Continue to partner with PACER Center, Inc., in targeting parents as a MAZE audience				X
3. Continue work with parent consultants to the Title V CSHCN program				X
4. Support medical home teams and their parent-members through Title V resources		X		X
5. Apply lessons learned about family involvement from medical home collaborative activities to the Development and Behavior Clinics of the CSHCN program	X			X
6. Provide financial recognition of parent time on medical home and other activities pursuant to the New Freedom Initiative grant		X		
7. Develop fact sheets for parents on genetic conditions of infants identified through the state's newly implemented birth defects surveillance system			X	X
8. Support parent membership on the State Interagency Committee (SIC) of the Minnesota System of Interagency Coordination (MnSIC)			X	X
9. Support outreach activities of the MnSIC process to parents on Interagency Coordinating Committee				X
10. Continue leadership in the Part C program and support of parents on both the ICC and the IEICs		X		X

b. Current Activities

Consultation for, and education of, parent members of the medical home teams continued through the end of 2004 and into 2005 through both a medical home learning session held in January and support for a medical home extranet. The Family Voices representative is a member of a small group of individuals that has been acting as the overall steering committee for medical home activities. This group will form the nucleus of a similar group for the New Freedom Initiative grant awarded by the Bureau to Minnesota in late April of 2005. Parents and advocacy groups were actively involved in the block grant needs assessment process described elsewhere in this application. A series of forums on the III-P concept, product and process (see NPM#5) were held over late 2004 and early 2005 to identify issues, barriers, problems and resolutions. Three forums were held with special education teachers, county social service personnel and local public health representatives. One forum was held for parent advocacy groups and one forum for all groups. The MCSHN director played a leadership role in

conducting these forums and is providing continued support for a strategy of involving more parents in this process through sustained outreach to local IEICs. The state was selected as one of the grantees in the Bureau's New Freedom Initiative, a grant in which parents will play key roles. Maze trainings have been described under NPM #4 and CSHCN staff conducted one such training in co-sponsorship with PACER Center targeted directly to parents of CSHCN.

c. Plan for the Coming Year

MAZE trainings will continue after MCSHN staff update material subsequent to the adjournment of the 2005 Legislature and MCSHN staff can analyze changes made to programs that support CYSHCN and their families. The MCSHN program will continue to work with parent advocacy groups for co-sponsorship of MAZE trainings targeted for parents. The MCSHN program will continue to support inclusion of parents on the governing body of the MnSIC III-P activity (see NPM#5) which will require legislative action and it will continue to support outreach to parent members of local IEICs as a strategy to build parent knowledge and information about the III-P concept, product and process. The MCSHN program will continue its collaboration in the operation of the Part C program of IDEIA with the departments of education and human services through an interagency agreement. This agreement supports the maintenance of the Part C program in Minnesota including Title V MCSHN membership on the Interagency Coordinating Committee (ICC) and technical consultation by Title V MCSHN staff to the 96 local Interagency Early intervention Committees (IEICs) throughout the state.

The Minnesota CSHCN program is one of the twelve grantees participating in "The President's New Freedom Initiative: State implementation Grants for Integrated Community Systems of Services for CSHCN". Activities involving parents in the first year of this grant (May, 2005-April, 2006), which overlap the current and upcoming federal fiscal year, include: a) Family Voices membership on the steering committee that will provide oversight for the grant's activities, b) organizing a statewide parent summit to identify a work plan for c) a parent work group to identify key issues that can be translated into 2-3 Issue Briefs per year for each of the three years of the grant and d) additional medical home teams, each with two parents, will be formed

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				48.7	48.7
Annual Indicator			48.7	48.7	48.7
Numerator				80059	
Denominator				164392	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	53.6	53.6	53.6	54	54

Notes - 2002

The 2002 indicator is based on the State estimates from the National Survey of Children with Special Health Care Needs (SLAITS).

Notes - 2003

Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving all children with special health care needs is related to the state priorities: "Promote family support, and healthy community conditions"; "Promote healthy parenting/family development"; "Improve mental health of children, youth and parents"; and "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Enabling Services; Population-based Services; Infrastructure Building).

The state began active implementation of its MCH Bureau Medical Home Grant when it hired a medical home coordinator in August 2003. The state then adopted the medical home learning model promoted by the National Initiative for Children's Health Care Quality (NICHQ) in its national medical home collaborative. Eleven teams were formed from clinical practices throughout the state with each team comprised of a pediatrician, a care coordinator, and two parents. Two learning sessions were held; one in March of 2004 and one in July of 2004. Faculty were drawn from nationwide expertise including the Center for Medical Home Improvement and selected faculty used by NICHQ in its national medical home collaborative activity. Several articles about Minnesota's experience were written and included in the state AAP chapter's newsletters; and several presentations were made to internal and external audiences about the state's medical home activities. Senior state Medicaid officials were briefed on the concept and the activities pursuant to the Bureau grant.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop strategies for spread and sustainability				X
2. Link information material about medical home to families of infants identified in newborn screening programs.			X	X
3. Link information material about medical home to families of infants identified through the Birth Defects Surveillance system.			X	X
4. Continue building the relationship with the state chapter of the AAP.				X
5. Explore reimbursement strategies for medical home with state Medicaid officials.				X
6. Continue efforts at integration of mental health services with medical home activities.	X		X	X

7. Promote concept of medical home through education of local public health personnel.				X
8. Pursue curricula development about medical home with appropriate university programs.				X
9. Update written material about medical home used by CSHCN program.				X
10. Work with state medical association, as it promotes medical home.				X

b. Current Activities

A third learning session was held in January 2005. Application of the Medical Home Index Tool by individual practices indicates that at the aggregate level there was a 42 percent increase in the mean score for the eleven practice teams as a whole between March of 2004 and January of 2005. Plans are to conduct a fourth medical home learning session for the eleven teams by September and to search for ways to more fully integrate mental health and transition activities into medical home activities. The state's Director of Children's Mental Health Services is an active participant in the learning sessions that have been held, is supportive of the concept and willing to explore areas where mental health initiatives and medical home activity can complement one another.

In February of 2005, the MCSHN program decided to participate in the second national medical home collaborative. The national collaborative presents opportunities to work more closely with state Medicaid officials to discuss financing and reimbursement issues. Minnesota formed four teams: a state-level team and three practice teams. Two of the three teams were part of the original state medical home initiative and one was completely new. The new team practices in a tertiary care institution in Minneapolis, the second team practices in a large regional city (St. Cloud) 90 miles northwest of the Twin Cities, and the third team is from a medium-sized town (New Ulm) in rural Minnesota 90 miles southwest of the Twin Cities. These teams attended the first national learning session in Dallas in March of 2005. The state medical association released a report of its Health Care Reform Task Force in January of 2005. That report, entitled Physicians' Plan for a Healthy Minnesota: The MMA's Proposal for Health Care Reform, makes a series of recommendations to increase the effectiveness of care. One of these recommendations is to "support a medical home for every adult and child in Minnesota…"and goes on to suggest that the MMA work to educate patients and payers about the concept. While the AAP definition of medical home differs substantially from that of the MMA, there are increasing opportunities for Title V/AAP promotion of medical home because of this MMA statement.

c. Plan for the Coming Year

The MCSHN program will continue its involvement in the national medical home collaborative. It will also continue medical home activities through other venues. First, Minnesota (as most other states) has submitted a grant application pursuant to the Bureau's Integrated Systems for CSHCN initiative. That application focused on existing assets and momentum within the state, one of which is the medical home effort. The state was notified in late April that it was one of the 12 states selected by MCHB for funding pursuant to this new initiative and the MCSHN program will continue working with the state AAP chapter, Family Voices, and other parent advocacy organizations to further the medical home concept. One of the major strategies to do so will be to work with the state chapter of the AAP to build its own infrastructure so it has increased resources to carry out medical home and similar activity. The current president of the state AAP chapter has been instrumental in the success of the medical home effort and all of his time commitment has been on a volunteer basis demonstrating the need for a more traditional administrative structure for the state chapter. Consequently, the MCSHN program will use its staff resources (time and expertise) to approach local and regional foundations for funding for up to three years to support a position similar to that of an executive director for the

AAP while the chapter pursues a more permanent funding source(s).

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				68.8	68.8
Annual Indicator			68.8	68.8	68.8
Numerator				113101	
Denominator				164392	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	70	70

Notes - 2002

The 2002 indicator is based on the State estimates from the National Survey of Children with Special Health Care Needs (SLAITS).

Notes - 2003

Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving children with special health care needs is related to the state priorities: "Promote family support and healthy community conditions"; Increase percent of children whose disability is identified early" "Increase percent of children who receive early intervention services" "Improve mental health of children, youth and parents." Program and Resource Allocation: Direct Health Care; Population-based Services; and Infrastructure Building)/

Minnesota has a very good record for insurance coverage of its children. Most state-specific studies indicate approximately 95 percent of children in this state have health insurance and that the majority of the 5 percent who do not have insurance are eligible either for Medicaid or for MinnesotaCare. However, the issue of the adequacy of insurance for CYSHCN has never

been addressed as rigorously as the question of whether they had any type of health insurance. The National Survey of Children with Special Health Care Needs conducted in 2001 did indicate that 68.8 percent of Minnesota's children with special health care needs had adequate insurance at the time of the survey. The most significant impact on coverage and/or adequacy of coverage for CYSHCN in the report year was the decision by the 2003 Legislature to substantially increase parental fees in the state's TEFRA program. This increase became effective July 1, 2003. There has been no documented research describing families dropping out of the TEFRA program because of increased parental fees, but the 2005 Legislature is reconsidering the fee increases based on anecdotal information to that effect. At the same time, other studies (described more fully below) are beginning to document an increasing percentage of adults employed in businesses of 100 employees or less. This has significant importance for both the percentage of children covered by private insurance and the adequacy of that insurance.

One area of continuing activity by the MCSHN program is that its staff is instrumental in educating community professionals about eligibility and coverage criteria of publicly funded, health insurance programs. This activity, called MAZE trainings ("Who Pays: Taking the Maze out of Funding"), provided 41 different training sessions to 995 individuals through these trainings during the report year.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update MAZE materials to reflect legislative changes				X
2. Analyze changes in publicly-funded, state health insurance and waiver programs enacted by 2005 Legislature				X
3. Promote and conduct MAZE trainings in communities throughout the state		X		X
4. Integrate MAZE trainings as a resource into medical home activity				X
5. Continue MCSHN support of Children’s Mental Health Services initiatives	X		X	X
6. Maintain and enhance the knowledge base about insurance of MCSHN personnel staffing its Information and Assistance toll-free line				X
7. Promote inclusions of appropriate CYSHCN-related insurance questions on surveys conducted by MDH programs				X
8. Explore the feasibility of developing a framework or structure to address issue of “adequate” insurance				X
9. Address the impact of availability of health insurance for small businesses and its impact on families of CYSHCN				X
10. Continue support of the zero to 3 diagnostic classification educational seminars conducted for mental health professionals	X			X

b. Current Activities

MCSHN continues its MAZE trainings and several medical home teams have requested presentations at their respective clinics. Insurance coverage was one of the top ten priorities identified by the CSHCN population work group in the 5-year needs assessment process as well as one of the top 15 priorities for all three population groups, although it was not one of the final 10 priorities adopted by the state Title V program. The MCSHN program has been working closely with the Children's Mental Health Services program of the state's department of human

services by supporting training sessions on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood™ (DC:0-3™). This is a classification system based on the recognition that young children suffer from mental health and developmental disorders and that a system for diagnostic classification sensitive to the developmental issues of young children was needed as well as one that can also be used as a basis for third-party reimbursement. The MCSHN program will provide logistical and financial support for two statewide training sessions on this system in state fiscal year 2006.
Although employer-based insurance decreased from 69.7 percent to 63.4 percent between 2001 and 2004, it remains the predominant source of insurance coverage for Minnesotans. A separate analysis of health insurance coverage published in February of 2005 documents a statistically significant increase between 2001 and 2004, in both the number of Minnesotans employed in a business size of 51-100 employees, and in the number of uninsured Minnesotans employed in a business size of 51-100. (Minnesota Department of Health, Health Economics Program, "Health Insurance Coverage in Minnesota, 2001 vs. 2004" February, 2005.)
These observations raise concerns about availability and affordability in addition to the unanswered question of adequacy and suggest several potentially troubling issues for CYSHCN and their families. For example, how does the observation that increasing numbers of Minnesotans are being employed in small businesses affect families of CYSHCN? Will employees in small businesses who have CYSHCN experience greater pressure to disenroll? Will their employer decide against health insurance for all employees because of high utilization of dependents of certain employees? What is the affordable cost share level for a family of CYSHCN compared to families without CYSHCN?
The major issue with meeting this performance measure will be the impact of changes to the state's publicly funded programs that occurred in the 2003-2004-legislative session. MCSHN is using parent consultants and experience with the MAZE trainings to update parents and professionals on these changes. The MCH Advisory Task Force workgroup is aggressively moving forward in identifying issues related to eligibility changes to public programs.

c. Plan for the Coming Year

The 2005 Legislature (scheduled to adjourn in May 2005) is reconsidering its 2003 action increasing parental fees for the TEFRA program as well as other actions on home and community-based waiver programs. These latter actions will impact CYSHCN and their families. MCSHN staff will analyze these changes, update the MAZE training material and conduct MAZE trainings in the community. Reimbursement strategies for funding of medical home will continue through the involvement of state officials (both Title V and Title XIX) in the national collaborative activity, support will continue for the DC:0-3™ training sessions and MAZE trainings will continue.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance				73.5	73.5

Objective					
Annual Indicator			73.5	73.5	73.5
Numerator				120828	
Denominator				164392	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.5	78.5	78.5	79	79

Notes - 2002

The 2002 indicator is based on the State estimate from National Survey of Children with Special Health Care Needs (SLAITS).

Notes - 2003

The indicator reported in 2002 have pre-populated the data for 2003 for this performance measure. Data from the National Survey of Children with Special Health Care Needs (SLAITS) administered 2000-02. Survey will be readministered in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving children with special health care needs is related to the state priorities: "Promote family support and healthy community conditions"; "Improve mental health of children, youth and parents"; "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Population-based Services and Infrastructure Building).

In 1998 Minnesota enacted legislation known as the Interagency Services for Children with Disabilities Act. This system, now formally referred to as the Minnesota System of Interagency Coordination (MnSIC) by its state and local partners, has as its purpose the "…development and implementation of a coordinated, multidisciplinary, interagency intervention service system for children ages birth through 21 with disabilities."

This legislation affects all agencies and educational organizations working with these individuals and their families and includes the state departments of health, human services, education, corrections, commerce, employment and economic development, and human rights. It also affects local community interagency committees serving children and youth with disabilities and their families.

A state appointed committee -- the State Interagency Committee (SIC) -- has been appointed to oversee and make key policy decisions about the development and implementation of this initiative at a state level. The Title V CSHCN director is a member of this policy-making body. The governing boards of the 96 plus local Interagency Early Intervention Committees (IEICs) are designated with the responsibility of designing and implementing their birth through 21 interagency system. The governing boards are members of local school boards and county boards. However, other local interagency groups such as the Family Services Collaboratives, Children's Mental Health Collaboratives, and Community Transition Interagency Committees

have responsibility to work in cooperation and coordination with this process. This coordinated birth through 21 interagency system is modeled after the Part C program of IDEA. The Title V CSHCN program has an interagency agreement with the department of education, which has been designated as the lead state agency for implementation of IDEA. This agreement delegates the Child Find responsibility pursuant to IDEA to the Minnesota Children with Special Health Needs program. The Infant Follow Along Program carries out implementation of this responsibility.

A significant portion of the report year was spent in a series of administrative forums with leadership of the state's special education teachers and parent advocates in an attempt to reconcile differences of opinion over the III-P concept, product and process.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with other state agencies to fully implement the III-P process.	X			
2. Create an updated, searchable, web-based central directory for Part C		X		X
3. Continue state support and technical assistance for the Infant Follow Along Program			X	X
4. Inform and educate providers, community professionals and parents about the ASQ-SE mental health screening component of the Ages and Stages Questionnaire			X	X
5. Continue active participation and leadership in statewide ICC, IEIC and Part C activities				X
6. Support Children's Mental Health Services of the Department of Human Services in implementation of DC: 0-3				X
7. Provide community outreach and training for Part C, III-P, ASQ-SE and Medical Home			X	X
8. Provide staff development of CSHCN program staff to enhance their expertise for technical consultation in above mentioned programs				X
9. Continue program presence and leadership for the State Interagency Committee (SIC) and its Interagency Management Team (IMT) and various committees				X
10. Integrate the state early childhood comprehensive screening systems activities to enhance effectiveness of existing screening and medical home activities			X	X

b. Current Activities

There are five areas of focus that the State Interagency Committee (SIC) adopted for the SFY 2005 (July 2004-June 2005) time period.

Those areas include communication, evaluation, transition, coordination of services and mental health. The Title V CSHCN Director is the "champion" for the communication area. This includes collecting input on challenges and opportunities, outreach to administrative stakeholders (special education), provision of information to families on the coordinated interagency system, increased awareness of MnSIC products and guidance materials, increased awareness and skills at the local level on systems development, provision of

technical assistance to local agencies on the coordinated system and support of local entities to provide ongoing training to local providers.

In addition, the MCSHN program has worked closely with the Children's Mental Health Services program of the Department of Human Services. The director of that program also serves as the current chair of the SIC committee referred to above. She is also the Principle Investigator of a grant from the Commonwealth Foundation (ABCD-II) directed to supporting children's mental health development through an integrated set of activities. One of these activities includes provider training in the Diagnostic Classification 0-3™ (DC:0-3™) system, which can be cross walked with the DSM-IV classification system thereby permitting young children with diagnosable conditions to access mental health services under the state's Medicaid system. The state Title V CSHCN program will co-sponsor two statewide training sessions in this methodology.

c. Plan for the Coming Year

The primary strategy for communication over the next few years rests with using the infrastructure of the 96 local Interagency Early Intervention Committees (IEICs). The implementation of the products and process of the MnSIC concept has faced resistance from the education system for a variety of reasons, two of which include the perception of financial exposure to school systems and the process being viewed as an unfunded mandate.

The legislation that enacted MnSIC stipulated that it was the right of the parent of an eligible child to use this system of coordinated care. The concept has not been fully embraced by all local school and county personnel thereby creating barriers for parents who wish to participate. The principal strategy to counteract this is to employ as many communication vehicles as possible with parent members of the IEICs.

Part C is the actual model upon which MnSIC itself is based. It is felt that there will be increasing numbers of parents with each successive year who are aware of the MnSIC system, understand that it is their right to participate in it and who will choose to do so.

Part C activities will continue and changes pursuant to the recent re-authorization of IDEA will be implemented. The Title V CSHCN program will continue to collaborate with the Children's Mental Health Services program through co-sponsorship of the DC:0-3™ training sessions and the program will also begin the implementation of the first year of its New Freedom Initiative Integrated Community Systems of Care for CYSHCN grant.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				5.8	5.8
Annual Indicator			5.8	5.8	5.8
Numerator				9535	

Denominator				164392	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.4	6.4	6.4	6.4	6.4

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving children with special health care needs is related to the state priorities: "Promote family support and healthy community conditions"; "Promote healthy parenting/family development"; "Reduce youth risk behaviors"; and "Improve mental health of children, youth and parents". (Program and Resource Allocation: Infrastructure Building).

The III-P and MnSIC product, process and concept have been described in detail in NPM#5. The III-P product and process was implemented in the following phases: children up to age 9 became eligible for this process in 2001, children up to age 14 became eligible in 2002 and children up to age 21 became eligible in 2003. The medical home activity had learning sessions in March and July of 2004. The July session included a presentation on transition.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue CSHCN involvement in MnSIC and III-P activities				**X**
2. Assure transition is a major topic in medical home learning sessions				**X**
3. Include transition expertise on the steering committee of the New Freedom Initiative grant				**X**
4. Continue to promote transition as a major topic to be addressed by the state chapter of the AAP			**X**	**X**
5. Continue CSHCN program involvement with the Minnesota State Council on Disability				**X**
6. Use analyses of the 2004 Minnesota Student Survey to identify transition issues				**X**
7. Assure youth membership and involvement in as many, if not all, groups formed to implement New Freedom Initiative grant				**X**

8. Promote transition issues as curricular components at university graduate programs on CYSHCN				X
9.				
10.				

b. Current Activities

The MnSIC activities described more fully in NPM#5 included transition as one of its five major work plan activities. The specific work activities were relatively modest and included an environmental scan of state agency activities about transition and an inventory of available support to transition age students.

c. Plan for the Coming Year

The Title V CSHCN director is a member of the MnSIC governing committee and will follow its activities on transition issues. The CSHCN program person serving as coordinator of the New Freedom Initiative grant is also the program person that will follow the MnSIC transition activity. Several activities pursuant to the New Freedom Initiative grant will touch directly or indirectly on transition issues. These include organizing a parent summit that will, among other things, identify a Parent Work Group to identify any issues. The state chapter of the AAP will hire a staff person to participate in policy work affecting all six core outcomes impacting CYSHCN including formation of a statewide Pediatric Council staffed by MN-AAP. All of these activities will either engage youth and transition challenges or include transition challenges as system issues (e.g., insurance, care coordination, reimbursement) are identified and solutions proposed.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	82.4	76.3	76.6	83.9	
Numerator	59421	50295	49053	55373	
Denominator	72138	65918	64037	65999	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

The percentage of children age 19 to 35 months old who have completed recommended immunizations is estimated from the National Immunization Survey. The denominator is estimated from the birth records, 19 to 35 months prior. The numerator is calculated as the percentage of children, age 19 to 35 months old, who have completed immunizations, multiplied by the denominator.

Notes - 2003

The percentage of children age 19 to 35 months old who have completed recommended immunizations is estimated from the National Immunization Survey. The denominator is estimated from the birth records, resident 2 year olds. The numerator is calculated as the percentage of children, age 19 to 35 months old, who have completed immunizations, multiplied by the denominator.

Notes - 2004

The data for 2004 are not yet available.

a. Last Year's Accomplishments

This performance measure serving all young children is related to the state priority "Promote family support and healthy community conditions." (Program and Resource Allocation: Direct Health Care: Population-based Services; Infrastructure Building).

Although Minnesota's statewide immunization rate always comes out in the top 15 states within the CDC studies, there are pockets of under-immunized children in some high risk populations. In Minnesota, the MCH Section is not the lead entity on immunization activities, rather the immunization program is housed in the Division of Infectious Disease Epidemiology. Title V staff collaborate with the immunization program by supporting and providing outreach and information, and providing immunization training sessions to providers through Child and Teen Checkup (EPSDT) trainings.

Minnesota's immunization registry, the Minnesota Immunization Information Connection (MIIC) is a statewide network of 7 regional immunization registries and services involving health care providers, public health agencies, health plans, and schools working together to prevent disease and improve immunization levels. In Minnesota, all parents of newborns are notified of their enrollment in the registry through Minnesota's birth record process and an immunization information packet given to them in the hospital. They are given an 800 number to call if they have questions or want to opt out.
The following "pockets of under-immunization" are evident in Minnesota:
·Children who live in low-income areas (Childhood immunization levels are as low as 45% in some low-income zip code areas.)
·High-risk children are behind on hepatitis B vaccine (Children who were born, or whose parents were born, in countries where hepatitis B virus is endemic are at high-risk of contracting hepatitis B but studies show that older high-risk children in this population are less likely to have received three doses of the hepatitis B vaccine.)

New rules were adopted to go into effect beginning with the 2004-2005 school year, requiring children in child care, kindergarten and seventh grade to show proof they are vaccinated against chicken pox (varicella) or have had the disease. Children under two years old in child care will need to show proof they are immunized against pneumococcal disease. Also effective in 2004, children entering kindergarten will need to show proof of a second dose for the measles, mumps and rubella vaccine. Medical and conscientious objections are allowed.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. Target information on immunizations to high-risk populations			X	X
2. Provide immunization training sessions to public and private providers through C&TC/EPSDT training			X	X
3. Assure immunization review part of WIC clinic services			X	X
4. Support local community immunization registries				X
5. Convene a meeting with immunization staff in Division of Infectious Disease Epidemiology to assess issues and strategize ways to collaborate.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V continues to provide information about immunizations, immunization requirements, access and availability, and other immunization related information through regular communication vehicles including the MCH electronic newsletter, the weekly WIC faxes, and listserv resources to child care health consultants, schools nurses, and family home visiting nurses. Information and education is provided to child care, home visiting, C&TC, and other local MCH staff, and information is downloadable from the MDH web site.

c. Plan for the Coming Year

Continue activities currently stated and convene a meeting with appropriate immunization staff to assess the current situation, special issues and needs, and strategize as to how we might further leverage our resources and capacities to address decreasing resources and immunization rates -- especially in higher-risk populations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15.9	15.9	14	13.5	13.5
Annual Indicator	15.5	13.9	14.2	13.4	
Numerator	1710	1529	1572	1467	
Denominator	110039	110039	110604	109237	
Is the Data Provisional or Final?				Final	

	2005	2006	2007	2008	2009
Annual Performance Objective	13	13	12.5	12.5	12.5

Notes - 2003

Source of data is MN birth records.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serves children and adolescents and is related to state priorities: "Promote family support and healthy community conditions"; "Reduce teen pregnancy and teen birth rate"; "Address the multifaceted needs of teen parents", "Reduce youth risk behaviors" and "Improve mental health of children, youth and parents. (Program and Resource Allocation: Direct Health Care: Population-based Services; Infrastructure Building).

Minnesota's teen pregnancy rate for 15-17 year olds for 2001-2003 was 19.9 per 1,000. For 18-19 year olds the rate increases to 65.5 per 1,000, for a rate of 38.2 for 15-19 year olds.

Approximately $5 million in MCH Block Grant, Title X and state funds were provided through grants to local public health agencies, tribal governments and non-profit organizations for family planning services (outreach, public information, counseling and method services) with approximately one-third supporting family planning services for teens.
A Family Planning and STI hotline is also supported by state funds and is staffed by individuals trained in information and referral as well as family planning and STD counseling. Almost 5,000 calls were handled by the hotline in 2004. Information on the hotline number is mailed to Medicaid/Minnesota/Care recipients each year.

Grant activities continued under the MN ENABL program include: 1) community organization activities implemented collaboratively by community groups and interested persons to reinforce the MN ENABL message; 2) use of a curriculum consistent with established principles; 3) a media campaign promoting the abstinence message; 4) state directed training and technical assistance for community-based projects. MN ENABL is funded by the abstinence dollars and 510 federal abstinence dollars. The MDH was designated by the Governor as the administrator of the Section 510 Abstinence Education program in the State. The federal application and annual report for 510 dollars was completed in March, 2005.

Title V and Reproductive Health staff partnered with Department of Human Services to develop a work plan regarding the implementation of the 1115 Medicaid Waiver.

The Adolescent Health Coordinator convened a Teen Pregnancy Prevention Brown Bag discussion group made up of community partners. This forum has provided the opportunity to communicate about issues impacting teen pregnancy prevention efforts.

The Adolescent Health Coordinator has also provided consulation and technical assistance to Eliminating Health Disparities Grantees who have focused on reducing teen pregnancy in high risk populations.

As one effort to support school based clinics, the Adolescent Health Coordinator provided 8 hours of time per month in one of the clinics seeing patients primarily for reproductive health issues.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support PRAMS data collection & analysis				X
2. Effective use of family planning services, including targeting Title X funds to high-risk minority teens	X	X	X	
3. Partner with DHS to successfully implement 1115 Waiver for family planning services			X	X
4. Increase public understanding of social, economic, & public health burdens of unintended pregnancy			X	X
5. Develop public understanding & support for policies & programs that reduce unintended pregnancies.			X	X
6. Continue abstinence programs that supports adolescents in their decision to postpone sexual involvement	X	X	X	X
7. Promote youth activities that support resiliency & healthy behaviors	X		X	X
8. Support hotline for family planning & STI services	X			X
9. Support school-based clinics & advocate for comprehensive reproductive education	X		X	X
10. Implement with others the state Teen Pregnancy Prevention Plan			X	X

b. Current Activities

Contracts for MN ENABL grantees were renewed until December, 2007. Currently 22 grantees throughout the state are funded.

The new grant cycle for Family Planning Special Projects (FPSP) grants began January 2004. Site visits to most of the 41 FPSP grantees were completed in 2004. FPSP grantees and MDH staff have met with DHS staff about implications for clinics with implementation of the 1115 Medicaid Waiver. MDH has provided key linkages between the provider community and DHS. Continued work in this area will be critical to successful Waiver implementation.

The Adolescent Health Coordinator has continued to facilitate the Teen Pregnancy Brown Bag sessions with community members. Technical assistance support has continued to the Eliminating Health Disparities grantees and has included reviewing teen pregnancy prevention curriculum and media campaigns targeted to high risk populations.

The Adolescent Health Coordinator has continued providing 8 hours per month of clinical service in one of the school based clinics.

c. Plan for the Coming Year

Continued coordination, collaboration and advocacy will be necessary to preserve and continue work regarding prevention of unintended pregnancy. MN has a strong history of building on existing partnerships and shared resources to reduce teen pregnancy.

The Teen Pregnancy Brown Bag sessions will continue to facilitate communication and collaboration between MDH staff and community partners.

The Adolescent Health Coordinator will be providing a BDI Logic Model and Evaluation Training to MDH grantees focused on teen pregnancy prevention and adolescent health promotion.

Reproductive Health staff and Title V staff will work with DHS to implement the 1115 Waiver. Reproductive Health staff will act as a liaison between DHS and providers, and collaborate with DHS to bring needed information and training to providers. MN ENABL grantees and FPSP grantees in partnership with MDH will provide critical direct services to MN adolescents in an effort to reduce teen pregnancy and teen birth rates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	13	14	15	16	17
Annual Indicator	11.1	9.3	10.0	10.4	
Numerator	12357	10653	12322	12861	
Denominator	111624	114050	123636	124201	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18	18	18	18	18

Notes - 2003

As reported, this indicator represents the percent of Medicaid-eligible children (ages 6-12) who received protective sealants. Data on protective sealants among third grade children in the general population are not available.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure that serves children is related to the state priority "Promote family support and healthy community conditions." (Program and Resource Allocation: Infrastructure Building).

The percent of children ages 8-12 eligible for Minnesota Fee-For-Service, Managed Care/Medical Assistance and MinnesotaCare programs that had sealants on one or more molar teeth has remained steady in the 10-12% range. Data on protective sealants among third grade children in the general population are not currently available.

The Division's oral health program provided oral health training, technical consultation, and educational materials to Community Health Boards, schools and the general public and worked with the Department of Human Services in areas of dental policy and access issues.

The C&TC staff provided training sessions to C&TC providers that included discussions of dental sealants and dental assessments.

With funding from HRSA, Minnesota Children's Oral Healthcare Access Project grant promoted the oral health of pregnant women and young children. Specifically the goal of the grantees was to improve the early oral health status of infants and children served by MN WIC programs, and improve the awareness and anticipatory guidance skills of WIC parents related to the oral health needs of their children.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the appropriate use of dental sealants to dental professionals & the public.			X	X
2. Work to develop strategies that make it easier for children to receive sealants.			X	X
3. Promote & encourage school-based/school-linked sealant programs & appropriate follow-up.			X	X
4. Work with the DHS to increase utilization of dental services for public program participants.			X	X
5. Continue to incorporate preventive dental practices in the C&TC trainings.	X		X	X
6. Integrate oral health anticipatory guidance into WIC clinic settings.	X		X	
7. Develop an Oral Health Data book of available and suitable MN specific oral health data.			X	X
8. Actively participate in the coalition to support and implement the campaign of Oral Health America “Smiles Across Minnesota.”			X	X
9.				
10.				

b. Current Activities

The Dental Health Program staff provides current, scientifically sound oral health information to individuals and groups as appropriate. Staff work with advocates including the Minnesota Dental Association, the Minnesota Dental Hygienists Association, the Minnesota Board of Dentistry and the Minnesota Department of Human Services on the multifaceted problems of dental access.

Currently under contract but not completed is a project from HRSA funding to develop a web-based oral health screening training curriculum to enhance the oral health of MN's children who are eligible for MN Child and Teen Checkup Program. This learning curriculum will be directed toward primary health care (non-dental) medical providers. It is anticipated that this attention to children's preventive oral health needs will ultimately improve the number of children who receive appropriate dental sealants.

The C&TC staff continues to provide Child and Teen Checkup training sessions that include discussion of dental sealants, dental screening and anticipatory guidance.

c. Plan for the Coming Year

Continuation of current activities with a particular focus on development of a Maternal and Child Oral Health Data Book. This Data Book will identify suitable and useful MN specific oral health data including dental sealants and other preventive oral health services that will improve knowledge and understanding of MN oral health issues and facilitate sound programmatic guidance.

In addition, MN has been identified by Oral Health America (a well-respected, independent national non-profit organization founded in 1955 and dedicated to improving oral health for all Americans -- www.oralhealthamerica.org) as one of five states nationwide to receive a major campaign to raise awareness of oral health's importance to total health. Dental sealant services, oral health coalition support and media and public education are the primary components of this "Smiles Across Minnesota" campaign that is anticipated to start in the fall.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	2.9	2.8	2.6	2.5	2.5
Annual Indicator	3.1	2.6	4.2	3.5	
Numerator	33	27	46	36	
Denominator	1060493	1039285	1085097	1024333	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.4	2.4	2.3	2.3	2.3

Notes - 2003

Source of data is death certificates.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving children and adolescents is related to the state priority "Promote family support and healthy community conditions." (Program and Resource Allocation: Direct Service; Enabling Services; Population-based services; and Infrastructure Building).

The motor vehicle crash child death rate (birth to age 14) per 100,000 in 2003 was 3.51 compared to 2.71 in 2001. Two Title V supported activities contribute to reducing risk of injury in a motor vehicle-related crash: 1) statewide distribution of car seats and booster seats to

those in need; and 2) intensive training of public health staff and local volunteers in the science of car seat and booster seat installation. Both activities were accomplished in partnership and collaboration with Minnesota SafeKids and the Department of Public Safety. Title V funding supports local injury prevention activities and, in 2003 more than 5,000 Minnesota children benefited from program support.

The Child and Teen Checkup (C&TC) program continued to provide training sessions to C&TC providers in 2003 that included anticipatory guidance on safety issues including car seats and seat belt use.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute car seats and booster seats; teach proper installation and use	X	X		
2. Train car seat and booster seat checkers			X	X
3. Support the GDL and “Click it or ticket campaigns of OTS, Department of Public Safety				X
4. Support, through data analysis, the shift in MN to standard enforcement of seat belts (Every body, every seat, every time)				X
5. Continue emphasis in Family Home Visiting and C&TC Training on using the home safety checklist with families being served			X	X
6. Support enforcement of speed limits, prevention of distracted and drowsy driving, and reduction of impaired driving – all of which places children at risk for motor vehicle crash deaths.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Current activities: distribute additional car seats / booster seats to those who need them; ensure adult women, teens and children are properly restrained in a motor vehicle; and improve dissemination of information on Minnesota's seat belt law.

The C&TC program will provide Child and Teen Checkup training sessions that include anticipatory guidance on safety issues including car seats and seat belt use.

We expect to see a reduction in crash death rates if health professionals advocate for motor vehicle safety instruction as a viable aspect of their daily responsibilities. Correct restraint needs to be modeled by parents and care givers, queried and taught by health professionals, and car / booster seats need to be provided to those who otherwise would not be able to afford them.

The Minnesota Legislature could strengthen enforcement of laws related to seat restraints, alcohol use by vehicle operators (our DUI limit of 0.08 will be implemented August 1, 2005), speed violations, and nocturnal teenage driving. Action in any of these categories will improve the health outcomes of Minnesota's children. Improvements in Minnesota's EMS and trauma care systems will reduce the risk of death post-crash. Minnesotans are driving more, however,

thus increasing exposure to and risk of motor vehicle crash injury and/or death.

c. Plan for the Coming Year

Continue activities currently stated. Particular challenges include protecting Minnesota's newest residents -- immigrants from Somalia and Southeast Asia.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	76	76	76	82	85
Annual Indicator	76.0	68.7	77.5	77.3	
Numerator	51226	45766	52694	54151	
Denominator	67403	66617	68034	70053	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	88	89	90	90

Notes - 2003

Rate from "Mothers Survey, Ross Products Division, Ross Laboratories" is applied to the number of births in the state to calculate the numerator.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure, which serves mothers, is related to the state priorities "Promote healthy parenting/family development" and "Promote family support and healthy community conditions". (Program and Resource Allocation: Population-based services and Infrastructure Building).

The estimated percentage of women who breastfed their infants at hospital discharge was reported as 77.3% in 2003, down from 79.5% in 2002 (Ross Laboratories Mothers' Survey). The new CDC Breastfeeding data from the National Immunization Survey reports the 2003 breastfeeding initiation rate for Minnesota as 79.5 +/- 5.1. Breastfeeding initiation rates for some special population groups, including refugee and low-income populations, are lower. The Hmong and Somali populations have lost breastfeeding traditions, upon immigration to the United States, the Hmong often ceasing to breastfeed and the Somali often continuing breastfeeding with supplementation. The video developed in 2003 on breastfeeding for Somali

women continues to be disseminated to WIC and other community partners. Native Americans also breastfeed at lower rates than the general population. Rates vary considerably between Minnesota communities. Progress continues but numerous barriers to breastfeeding remain in the general population, and immigrant populations face additional barriers.

Increasing the duration of breastfeeding continues to be a challenge. Research demonstrates a dose-response to breastmilk, with greater benefits for exclusive breastfeeding and longer durations of breastfeeding. In 2003 breastfeeding duration to 6 months was reported as 41.3% (down from 45.1 % in 2002) for the general population and 17.5% (down from 26.6 % in 2002) for the low - income population. (Ross) CDC reports that 44.7% +/- 6.1% of the general population reports duration to at least 6 months. The HP2010 goal is 50%.

Breastfeeding is encouraged and supported through the Family Home Visiting program, and local public health activities. Family Home Visiting (FHV) consultants distribute breastfeeding materials at site visits to the local public health agencies and the tribal governments as well as at other meetings, such as MCH Coordinators' meetings. Distribution of breastfeeding materials is also done through FHV e-mail lists and on the FHV website. The Minnesota WIC program implemented multiple activities to promote and support breastfeeding, with many of the populations targeted by MCH. WIC invited a variety of community partners to breastfeeding workshops and meetings held throughout the state to increase communications and to build skills in breastfeeding counseling.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure that MCH Public Health Strategies on breastfeeding promotion continue to be available			X	X
2. Work to assure that breastfeeding promotion and support remains a component of the Family Home Visiting program	X			X
3. Continue to provide breastfeeding education & support through WIC, ie training and technical assistance to local WIC programs, and local programs provide breastfeeding support services to WIC participants.	X		X	X
4. Provide technical assistance and training to local programs to help them identify opportunities and implement strategies to promote and support breastfeeding.			X	X
5. Implement WIC Peer Breastfeeding Support	X			X
6. Continue to convene cross-program meetings to identify ways to integrate breastfeeding promotion & support into a wide array of MCH programs.				X
7.				
8.				
9.				
10.				

b. Current Activities

A fact sheet on breastfeeding was developed. A Family Planning Special Projects grantee is promoting LAM (lactation amenorrhea method) to populations that don't accept other methods of family planning. Informal sharing of information and opportunities to promote and support breastfeeding is shared within the MCH program and between MCH and WIC. We have begun

to meet to discuss breastfeeding activities across MCH programs. Local public health staff, supported by MCH Block Grant funds, advocate breastfeeding and include breastfeeding promotion strategies in contacts with families.

WIC staff continue multiple activities to promote and support breastfeeding. The annual WIC Conference includes specific breastfeeding sessions. WIC continues to offer workshops on breastfeeding counseling, in locations throughout the state. Workshops are attended by WIC staff and their community partners. WIC Breastfeeding Coordinator participated in the 5 year MCH needs assessment process. WIC added breastfeeding information for parents and staff to their website.
WIC is developing a peer breastfeeding support pilot program that will be implemented in the spring and summer of 2005.

c. Plan for the Coming Year

Continue to develop linkages to promote and support breastfeeding, including meeting with MCH staff to discuss breastfeeding promotion and support, and practices within communities that can hinder breastfeeding. Continue to place special interest in our newest cultural/ethnic populations. Investigate partnering for breastfeeding training. The MCH website may be updated to include links to breastfeeding information.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	65	85	95	98
Annual Indicator	61.0	75.0	59.3	77.0	
Numerator	42573	50566	38106	53904	
Denominator	69795	67422	64213	70006	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	99	99

Notes - 2002

The denominator is less than the total number of infants born in the state because not all birthing hospitals report on hearing screening.

Notes - 2003

Rate is based on 85% of the 111 hospitals in MN that report directly on the occurrence of a newborn hearing screening. The remaining 15% of hospitals conduct the hearing screening but

do not report.

Denominator is the number of births in the State.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving all infants is related to the state's priorities: "Increase percent of children whose disability is identified early" and "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Infrastructure).

The estimated percentage of newborns screened for hearing loss has been adjusted to 85% in 2003 and 81% in 2004. This percentage is based on the data from 85% of total birth hospitals that report data to the state (94 out of 111) rather than the direct ascertainment of infants screened. In the past, the numerator was calculated using information from direct reports for reporting hospitals and an estimate of 100% of newborns screened for non-reporting hospitals. This overestimated the occurrence of screening, since non-reporting hospitals are also likely to have occasional barriers to screening. By the end of the year 2004, 109 of 111 birthing hospitals and 6 NICU/Special Care Nurseries reported implementation of newborn hearing screening.

Two federal funding sources provide substantial support to this Title V performance measure. The HRSA MCHB universal newborn hearing screening and intervention (UNHSI) grant (4/00-3/05) primarily supported expansion of screening in hospitals and methods to connect families to services. The CDC cooperative agreement (10/00-9/05) focused on the continued enhancement of a statewide tracking and surveillance system and education/training of health care providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance on implementing newborn hearing screening to hospitals and communities			X	X
2. Provide education & training of providers, including audiologists			X	X
3. Provide information to parents of the importance of screening & if identified with a hearing loss, additional follow-up			X	X
4. Refine & expand the data tracking & follow-up system			X	X
5. Integrate data collection, follow-up & tracking with newborn metabolic screening			X	X
6. Work with a variety of stakeholders on assuring follow-up, referral & intervention for infants		X	X	X
7. Continue federally funded grant activities in this area		X	X	X
8. Support hospital quality assurance activities		X	X	X
9.				
10.				

b. Current Activities

The MDH tracks newborn hearing screening results through integration with the state's Newborn Blood Spot Screening database and proposed matching with vital statistics. Title V

staff continues to partner with the Departments of Human Services and Education to provide state leadership in early hearing detection and intervention, including tracking and reporting of outcomes. The 16 Regional EHDI teams continue to build the capacity in their regions to better serve deaf/hard of hearing children and their families. A new MCHB UNHSI grant was awarded (4/1/05-3/08), albeit at a 30% funding reduction, to continue supporting hospitals and increase follow-up activities.

In addition, MDH continues to provide ongoing technical support to hospital screeners. Staff collaborate with and provide trainings to public health nurses, physicians and other early interventionists. Title V has continued to collaborate with the University of Minnesota (U of M) Department of Otolaryngology to assure current competencies in infant audiologic instrumentation, testing procedures, protocols, and counseling. The U of M facilitated the addition of one Regional Audiology Diagnostic and Habilitation Center in South Dakota. MDH now recognizes eleven Centers. In addition, the U of M conducted one didactic and hands-on training workshop for audiologists and other providers.

MDH also collaborates with contracted Lifetrack Resources, a non-profit group, to develop a statewide family-to-family support network. Through the CDC cooperative agreement, two contract audiologists provide consultation to screening and non-screening hospitals.

Emphasis this past year was centered on implementing screening programs in remaining hospitals. Reimbursement remains an issue for long-term sustainability of a statewide voluntary screening, tracking and follow-up system.

c. Plan for the Coming Year

Focus will be on hospital reporting data to the state and quality improvement of the screening programs. The MDH has reapplied for a new CDC coop agreement (7/05-6/08) to continue development of an early hearing detection and intervention public health surveillance system. Further enhancement of the data tracking and follow-up system will assure that children are screened by one month of age, diagnosed by 3 months of age, and offered culturally appropriate early intervention by 6 months of age. To assure these 1-3-6 goals, provider and parent education activities will aim to reduce loss to follow-up and will focus on developing sustainable EHDI quality assurance programs for hospitals and communities. In addition, program staff will target midwives (home births) and establish agreements with border states to assure the 1-3-6 goals for all children in Minnesota.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3.2	3	2.8	2.6	2.4
Annual Indicator	5.8	6.4	6.5	6.5	
Numerator	74640	84039	81784	86173	
Denominator	1286894	1313116	1258216	1325744	

Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.2	2.2	2.2	2.2	2.2

Notes - 2003

Performance indicator from 2002 applied to 2003 because no new data are available. Source of 2002 data is the BRFSS.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving infants, children and adolescents is related to the state priorities: "Promote family support and healthy community conditions" and "Increase percent of children whose disability is identified early" (Program and Resource Allocation: Population-based Services and Infrastructure Building).

Based on the 2004 Minnesota Health Access Survey (which is different than the final 2003 numbers we are using for this National Performance Measure) we are seeing a general increase in uninsured Minnesotan's (from 5.4% in 2001 to 6.7% in 2004). This increase was driven by a decrease in employer-based health insurance coverage, a shift in Minnesota's income distribution, and a change in Minnesota's Hispanic/Latino population. In 2004 Minnesotans were more likely to be uninsured or covered by public health insurance programs and less likely to be covered by group or employer-based health insurance coverage than they were in 2001. Our rates of uninsured continue to show disparities based on race, with the change being most pronounced for Hispanic/Latino Minnesotans.

Between 2001 and 2004 uninsured rates increased for all children (birth-17) from 6.4% to 7.7%. In the Black population (birth-17) rates decreased from 16.9% to 12.4 %, but this is still almost double the White rate of 6.4%. The overall non-White rate for 2004 is 16.0% with Hispanic being highest at 31.6 % (up from 19.7% in 2001).

Within the Birth to 5 year old group, the uninsured rate rose from 5.7% in 2001 to 9.2% in 2004. The non-White rate remained relatively stable, while the White uninsured rate increased from 4.2% to 8.0%. This Birth to 5 year old uninsured rate is higher than the overall uninsured rates for the 6-12 age group (7.0%) and the 13-17 age group (7.1%).

These rates may have been influenced by policy changes from the 2003 legislative session, which went into effect on 7/1/2003. The Children's Defense Fund of Minnesota estimated these would negatively impact 20,000 children's insurance status.

Work of Title V staff is primarily around increasing enrollment in insurance and in working to influence policy around eligibility and benefits. MCSHN staff continued to provide Maze trainings (Taking the Maze out of Funding) to educate families and providers on health care programs eligibility and access, particularly in light of recent policy changes. MCSHN also includes health insurance information in their Parent Packets. State staff in Family Home Visiting and WIC provided updated information to local practitioners to support their role in assessing child health insurance status and referring appropriately. The Maternal and Child Health Advisory Task Force continued it's work group to monitor the outcomes of policy changes on the health status of children and mothers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide MAZE trainings for parents and professionals				X
2. Work with the DHS to assure that all children eligible for public programs are enrolled		X	X	X
3. Work within existing systems to assist families in identifying insurance options				X
4. Continue to participate on the BUILD Coalition				X
5. Update and distribute the Part C Central Directory and the Parent Information Packets		X		X
6. Maintain insurance coverage component of the Family Home Visiting program			X	X
7. Develop communication plan for using information related to health insurance from MCHBG and Needs Assessment to educate and inform providers, families, planners and policymakers.				X
8.				
9.				
10.				

b. Current Activities

The Title V Director participates in the statewide Coalition (BUILD) for improving children's access to health care coverage. MCSHN has continued to analyze policy changes affecting programs and eligibility and incorporate updated information into their Maze trainings. Title V staff have continued to work with staff in the Health Economics Section to look at issues of special significance for children in relation to insurance status. A report is being written summarizing work and findings to date of the MCHATF work group monitoring outcomes of policy changes. Several Title V staff have been very active in the planning for Statewide Outcomes under Minnesota's revised Local Public Health Act. One of the outcomes under the Essential Service of "Assuring the Quality and Accessibility of Health Services" is to Increase the number of clients who are enrolled in health insurance programs. This has provided a nice opportunity to plan for work at both the state and local level for activities aimed at increasing health insurance rates for children. This work is still in progress.

c. Plan for the Coming Year

Continue all activities noted above in current year, with a special attempt to develop good strategies for using the information in the Title V block grant and from the Needs Assessment to educate and support local health and related practitioners, families, and state level planners and policymakers around issues of insurance for children.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87.2	89.6	89.9	90	90.1
Annual Indicator	86.9	86.6	88.1	88.1	87.6
Numerator	315759	310156	355851	355484	397000
Denominator	363296	358000	404000	403484	453000
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90.2	90.2	90.2	90.2	90.2

Notes - 2004

Numerator is an estimate of the number of uninsured who are potentially eligible for Medicaid and MNCare.

a. Last Year's Accomplishments

This performance measure serving infants, children and adolescents is related to the state priorities: "Promote family support and healthy community conditions"; "Increase percent of children whose disability is identified early; and "Increase percent of children who receive early intervention services". (Program and Resource Allocation: Enabling Services; Population-based Services; and Infrastructure Building).

To support this performance measure, Title V staff are primarily involved in increasing enrollment in to public health care programs and in providing training to health care providers about the programs. MDH Child and Teen Checkup (C&TC) staff provided outreach promotion activities to increase participation in the Medical Assistance (MA) C&TC program. These activities included discussions of the MA application process and forms during training for PHNs, school nurses, and county C&TC coordinators; outreach training and technical assistance to C&TC coordinators to increase their outreach to public and private C&TC providers; and advising health professionals and families about medical care funding sources during consultant visits with local public health agencies. Under contract with the Minnesota Department of Human Services (DHS) Title V staff offered an extensive schedule of C&TC training sessions to health care providers. On-site follow-up consultations and clinic flow assessments were provided by a MDH certified pediatric nurse practitioner for newly trained nurses and refresher training was offered to more experienced nurses.

MCSHN continued activities aimed at increasing MA and MinnesotaCare enrollment. In the 2003 legislative session, Minnesota experienced significant policy changes affecting eligibility for and enrollment into these public health care programs. MCSHN analyzed these changes and provided in-service training around the state to professionals and families regarding the changed requirements and application processes. MCSHN continues to receive calls involving MA, MinnesotaCare, TEFRA, and SSI eligibility, enrollment and appeals rights and will send out applications for MA or MinnesotaCare as appropriate. MCSHN sends letters to families that apply for SSI benefits advising them they may qualify for MA if SSI eligible.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Provide technical assistance and training to communities related to eligibility criteria and enrollment procedures for public programs.				X
2. Provide consultation, technical assistance, & training regarding services provided under Medicaid.				X
3. Work with DHS on strategies to improve percent of children who receive a service paid by Medicaid				X
4. Staff and advertise the MCSHN 1-800 number to help families understand the public programs they may be eligible for and how to use Medicaid	X	X	X	X
5. Monitor availability of Medicaid providers and enrollment				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V staff assist in regional C&TC outreach meetings sponsored by the DHS, and participate in health plan and county C&TC Outreach Coordinator sponsored regional meetings for clinic staff and providers. Title V staff continue to collaborate with DHS in the planning, development and evaluation of the components and standards of the C&TC program. Through formal and informal relationships with DHS, Title V provides technical support to public and private C&TC providers, and to Outreach Coordinators in their efforts to inform clients and providers regarding C&TC, and provides statewide training for MA providers to increase quality comprehensive preventive health visits.

MCSHN continues to conduct outreach activities through a number of outlets and provide information on the MA and MinnesotaCare programs through clinics and in-service training to community members, families, and professionals. The MCSHN information and assistance (I&A) line continues to provide information about medical funding sources, including MA; and will send out MA applications to potentially eligible families who call the I&A line. The professionals staffing this line assist families in mapping out access to needed health and related services appropriate to their child's specific health concern. In addition, MCSHN continues to send out letters to families with children who are found either medically eligible or denied SSI benefits, to encourage them to apply for Medical Assistance.

MCSHN has been an active participant in the process underway to expand the interagency collaborative partnership established by Part C of IDEA all the way up through age 21. A single individualized plan is developed for each child/youth through a collaborative process at the community level. This process will help identify children who are eligible for MA but not enrolled and those who are enrolled but not receiving health and health-related services. MCSHN has been actively involved in the development of the single plan and is currently providing training and technical assistance to local agencies on both the plan itself and on the public health care programs.

c. Plan for the Coming Year

Continue activities currently stated. Again, once this legislative session ends, staff will analyze changes to public health care programs eligibility and enrollment procedures, and provide

updated information and trainings to families, community members, and providers.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.05	1	1	1	1
Annual Indicator	1.1	1.2	1.2	1.1	
Numerator	746	819	828	760	
Denominator	67403	66587	68010	70023	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	0.9	0.9	0.9	0.9

Notes - 2003
Source of data is birth certificates.

Notes - 2004
The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving adolescents and all women of child bearing age is related to the state priorities: "Reduce drug, alcohol, and tobacco use"; "Promote family support and healthy community conditions"; and "Reduce teen pregnancy and teen birth rate"; (Program and Resource Allocation: Direct Health Care; Enabling Services; Infrastructure Building).

The percent of very low birth weight infants decreased to 1.1 in 2003 representing 760 births down from 828 in 2002. Data from 2003 indicate that overall low birth weight remained the same as 2002 at 6.3 percent. Racial and ethnic disparities, especially in low birth weight, continue to exist and the overall African American low birth weight rate remains more that 2 times the white rate which is 4.0 percent.

In Minnesota, Title V funds are used by Local Community Health Boards (CHBs) to carry out a variety of activities aimed at decreasing the number of low-birth weight births, including free pregnancy testing, public health nurse initial assessment, education, counseling and referral. Women who are at high-risk and income eligible or Medical Assistance eligible were enrolled in improved pregnancy outcome services that included: public health nurse home visits which focused on assessment, monitoring, nutritional counseling, prenatal education, preterm birth prevention education, case management and follow-up. As their budgets were cut in 2003, many CHBs cut back on home visiting and relied more on group education. Other activities funded by Title V at the local level include enabling services such as the provision of

transportation, translation, outreach, health education, family support services, and case management.

The Twin Cities Healthy Start program seeks to reduce the disparity in infant mortality experienced by African American and American Indian families in Minneapolis and St. Paul. The Healthy Start Collaborative, which includes representatives from Healthy Start, Title V, Title XIX, and health plans, was established to review institutional barriers, integrate perinatal services, and plan for sustainability of project efforts. Title V staff provide technical assistance and resources to grantees of the Eliminate Health Disparities Initiative (EHDI), working to eliminate disparities in infant mortality. These activities include implementation of doula programs, development of culturally appropriate health education materials, faith-based health initiatives with families and youth, outreach, social support, home visiting, and case management during pregnancy and infancy. Additionally, health education and health promotion activities are implemented in conjunction with clinical services already provided. As part of the EHDI, the state provided non-competitive funding to Minnesota's eleven tribal governments, five of which are addressing infant mortality with these funds.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide TA & support to Eliminate Health Disparities Initiative grantees that have selected the priority of reducing infant mortality			X	X
2. TA to local public health & community-based organizations to reduce racial/ethnic disparities in poor birth outcomes				X
3. Collaboration with external partners on provider & other professional education			X	X
4. Implementation of the Department Perinatal Health Plan				X
5. Utilization of PRAMS, birth & death data to plan programs & target resources				X
6. Provide subsidized family planning services to low-income high-risk individuals	X	X		
7. Continue to support Teen Pregnancy Prevention activities	X	X	X	X
8. Continue activities to reduce substance use & abuse during pregnancy		X	X	X
9. Work to offer Family Home Visiting program & WIC services to all eligible pregnant women			X	X
10. Support work at local level to provide services to high-risk individuals such as transportation, translation, etc.		X		

b. Current Activities

Title V staff provides technical assistance on a variety of maternal and child health activities conducted by the eleven tribes of Minnesota. The MDH Tribal Health Coordinator, a position located in the Office of Minority and Multicultural Health, coordinates all of MDH's technical assistance to the tribes, including that of the MCH Section.

Title V staff provides technical assistance to Community Health Boards and other community organizations regarding improving systems to identify and refer women who are pregnant and at risk of poor outcomes. Activities include training of public health nurses and para-professionals in assessment and intervention skills related to domestic violence, alcohol, tobacco and other drug use during and after pregnancy, teen pregnancy and parenting.

Limited PRAMS data became available in Summer 2004 based on 8 months of PRAMS surveys conducted during 2002, the first year of Minnesota's project. Combined with birth certificate and other data, it was primarily used when Title V staff wrote fact sheets as part of the 5 year MCH Needs Assessment prioritization process that took place during the last half of 2004. PRAMS provided data on risk factors for low and very low birth weight including mental health, access to care, pregnancy intendedness, and social support. These data are critically important for MCH program planning in Minnesota as we no longer have statutory authority or funding for fetal and infant mortality review projects.

Title V staff participates in the metro Maternity Case Management Excellence project which is addressing care coordination issues for high risk pregnant women in Minneapolis and St. Paul. This is a collaborative project with local public health, community health centers, community-based organizations, including Twin Cities Healthy Start, and the health plans. With guidance from a CDC Fellow and funding from a foundation grant, progress is being made to assure that pregnant women's risk factors are identified and appropriate services are provided. Biannual meetings provide opportunity for monitoring progress and enhance communication among partners. Reducing low and very low birth weight as well as infant mortality are goals of this project.

Title V staff work with the State March of Dimes chapter to plan and participate in Minnesota's annual Prematurity Summit and reviews local grants for March of Dimes. Active participation and support of the March of Dimes' initiative to educate the public and professionals about causes and consequences of premature birth is a key activity to reduce low and very low birth weight births in the state.

c. Plan for the Coming Year

Continue activities currently stated-- Also see "NPM #18" regarding early prenatal care.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.7	8.6	8.5	8.4	8.2
Annual Indicator	7.7	10.3	8.9	10.1	
Numerator	29	37	34	38	
Denominator	374362	357513	383051	376843	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	8	8	8	8	8

Notes - 2003

Source of data is death certificates.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure servicing children and youth is related to the state priorities: "Promote family support and healthy community conditions"; "Reduce youth risk behaviors"; and "Improve mental health of children, youth and parents". (Program and Resource Allocation: Population-based Services and Infrastructure Building).

The suicide death rate (per 100,000) among youth aged 15-19 years decreased from 10.6 in 1996 to 7.7 in 2000 and then increased to 10.3 in 2003. There were 37 deaths in 2001, 36 suicide deaths in 2002, and 28 suicide deaths among youth in Minnesota in 2003.

Work has continued to implement our statewide suicide prevention plan developed in 2000 in consultation with a large group of stakeholders. In 2001, the governor recommended, and the state legislature approved, an appropriation of $1.1 million annually to MDH to strengthen the capacity of state and local public health to work with communities to address suicide prevention. The suicide prevention advisory group continues to meet. Additionally, the K-12 Suicide Prevention Workgroup and the American Indian Suicide Prevention Workgroup started in 2003 has continued in 2004 to further refine and implement the individual strategies outlined in the plan.

Eleven second round community grants were awarded in January 2004, and two additional grants in the fall of 2004. Two of the grantees received targeted technical assistance grants and partner with the MDH to provide suicide prevention training and statewide resources to grantees and other communities. This public--private partnership is a hallmark of Minnesota's unique approach and is one that enhances the roles of all partners.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementation of state suicide prevention plan			X	X
2. Provide grants management for suicide prevention grantees				X
3. Technical assistance to public health & other community agencies				X
4. Participate actively on the State Advisory Council on Mental Health				X
5. Continue to support youth activities that support resiliency & healthy behaviors			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MDH staff continues to work with suicide prevention grantees, local public health agencies and other statewide stakeholders to implement and document progress on the state suicide prevention plan. This includes convening, coordinating and providing ongoing assistance to suicide prevention stakeholders. The K-12 and American Indian suicide prevention workgroups are continuing.

c. Plan for the Coming Year

The state funding for suicide prevention activities, both the state FTE and grant dollars, is slated for elimination, but still under discussion at the legislature. Depending on the outcome and remaining resources, we will continue to support this work as best we can. We are also applying for new federal mental health funding.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	89	90	96	79	80
Annual Indicator	85.7	96.0	77.5	76.8	
Numerator	589	752	642	584	
Denominator	687	783	828	760	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	83	84	85	85

Notes - 2002

Minnesota's data on this performance measure has worsened significantly. Specifically, one urban hospital with a large number of annual births to high risk women converted from a Level III high risk perinatal center to a Level II in January, 2002.

Notes - 2003

Birth record data and hospital information are used for this measure.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving pregnant women is related to the state priority: "Promote family support and healthy community conditions". (Program and Resource Allocation: Infrastructure Building)

In 2003, there were 760 births of infants weighing 1,500 grams or less. Of the 705 born in Minnesota, 584 or 82.8 percent were born in facilities appropriate for high risk very low birth weight deliveries. This represents an improvement from 2002 when only 77.5 percent were born in such facilities (See section b).

The Minnesota Perinatal Organization (MPO) and the Minnesota March of Dimes are examples of two organizations whose purposes focus on healthy pregnancy outcomes. The Title V staff are involved with both groups in program planning for health professionals. The MPO targets all health professions involved in perinatal care by providing educational conferences to improve the health care of pregnant women and newborn infants. The March of Dimes focuses on both consumer and professional education. Title V and other health department staff work closely with March of Dimes on professional and consumer education on folic acid, preconception care, disparities in infant mortality and other birth outcomes, birth defects, and is collaborating with March of Dimes on their new prematurity education and research campaign.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the status of perinatal centers in Minnesota				X
2. Collaborate with external partners such as the March of Dimes and the MN Perinatal Organization				X
3. Promote guidelines for Perinatal Care			X	X
4. Monitor the number & place of birth for high-risk deliveries				X
5. Actively participate in maternal case management collaborative meetings to improve maternity and infant care for diverse and low-income families.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

There is continuing health system resistance to designation and expected utilization of regional high risk care centers. Minnesota's data on this performance measure worsened significantly, when an urban hospital with many annual births to high risk women converted from a Level III high-risk perinatal center to Level II in January, 2002. The same managed care entity, had two level III hospitals within 10 miles of each other and opted to reduce one of them to a level II. Title V staff will continue to monitor this data for changes.

Title V staff will monitor births of very low birth weight infants according to "Guidelines for Perinatal Care" 5th edition, 2002, published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).

c. Plan for the Coming Year

Continue activities currently stated. Title V staff will explore opportunities to educate providers about the importance of high-risk deliveries occurring at appropriate facility levels.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	86.2	87.1	87.9	88.8	89.7
Annual Indicator	84.9	84.6	85.5	86.5	
Numerator	53946	54090	55987	57935	
Denominator	63574	63916	65490	66963	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90.5	90.5	90.5	90.5	90.5

Notes - 2003

Source of data is birth records.

Notes - 2004

The 2004 data are not yet available.

a. Last Year's Accomplishments

This performance measure serving adolescents and all women of child bearing age is related to the state priorities: "Promote family support and healthy community conditions"; "Improve mental health of children, youth and parents"; and "Reduce teen pregnancy and teen birth rate." (Program and Resource Allocation: Direct Health Care; Enabling Services; Population-based Services; and Infrastructure Building)

In 2003, 86.5 percent of infants were born to women receiving care beginning in the first trimester, representing a marginal increase from 85.5 percent in 2002. In 2002, Minnesota ranked 17th among the states and territories. Yet Minnesota's rank for Black women starting prenatal care in the first trimester was 7th worst, at 70.0 percent. The rate for Hispanic women in Minnesota was 68.0 percent, 13th worst. (Rankings among the states on first trimester prenatal care for 2003 are not yet available from the National Center for Health Statistics.)

During the 2003 Minnesota legislative session changes were made to Minnesota statutes as they relate to the Local Public Health grant, including MCH activities. One of the most significant features is the new focus on accountability that required the development of statewide outcomes, focused on improving health, and to be associated with a set of essential local activities. During 2004, Title V staff, local public health and individuals interested in maternal and child health developed these outcomes. One of the approved statewide outcomes is "Increase the number of pregnant women receiving early and adequate prenatal care." The Commissioner of Health is charged with monitoring and evaluating whether each community health board has made sufficient progress toward the selected outcomes. Concurrently, the MCH Advisory Task Force worked to monitor the impact of state budget cuts on funding for

maternal and child health services at the local level.
Title V staff continued to work with public health agencies, representatives of managed care, and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification of pregnancy, pregnancy intent, and early initiation of prenatal care is emphasized. Populations within the geographic district who have the lowest rate of initiation of early prenatal care are targeted to improve those rates. Examples of initiatives to improve the numbers of women who initiate early prenatal care include the Twin Cities Healthy Start Program, the Nurse Family Partnerships in St. Louis and Clay counties, and the Maternity Case Management Excellence project in Minneapolis and St. Paul.

Local Community Health Boards (CHBs), with Title V support, promoted the initiation of prenatal care in the first trimester. Some provided free pregnancy testing with referrals for appropriate services. Women whose pregnancy test is negative are also counseled regarding family planning and healthy pre-pregnancy practices.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement the Department Perinatal Plan		X	X	X
2. Support activities that focus on primary health care, family planning, & medical homes for women	X	X	X	
3. Continue involvement on the Healthy Start grant			X	X
4. Partner with racial & ethnic communities to identify & implement strategies for improving early prenatal care				X
5. Continue partnerships related to community health worker program				X
6. Improve statewide universal and system capacity to provide perinatal mental health care.				X
7.				
8.				
9.				
10.				

b. Current Activities

In greater Minnesota, as reported by CHBs, state district nursing consultants, and state and local WIC staff, some providers and clinics are routinely instructing some of their patients to wait until their second trimester before coming in for prenatal care. Early and adequate prenatal care for all of Minnesota's pregnant women is one of the ten priority areas identified in the five year MCH state needs assessment. For the next five years it will be a priority activity of state Title V staff.

CHBs continue various activities to promote the initiation of prenatal care in the first trimester. Outreach activities are fundamental to increase the number of women who will begin early prenatal care. CHBs initiate and maintain collaborative relationships with other community organizations frequented by women of childbearing age. By reinforcing the importance of early pregnancy identification and referral as well as healthy life styles to community-based organizations and the women they serve, the opportunity for impacting attitudes and behavior is increased. CHBs promote such messages through collaborations with area health clinics, hospitals, extension services, social services, schools, Head Start programs, and early child and family education programs. Title V staff are partnering with state colleges and universities

to pilot a curriculum of education for community health workers (CHW). It is anticipated that CHW's will extend the reach of the health system, including public health nurses and clinics, to serve more people, particularly populations of color, immigrants, and American Indians. This will be a long-term effort with results to be determined in the future.

c. Plan for the Coming Year

This performance measure is addressed in Title V's Perinatal Plan (See attached .pdf file.) and was identified as a priority in the MCH needs assessment. Title V staff will address the overarching issues leading to delays in prenatal care: pregnancy intendedness, family planning, preconception care, primary health care, and establishing a medical home, and will work collaboratively with communities to promote culturally appropriate education and awareness regarding the importance of early prenatal care, and to address disparities in accessing early prenatal services.

This performance measure has a close relationship to "National Performance Measure #15: The percent of very low birth weight infants among all live births."

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of children, aged birth to three, who are provided with ongoing screening for developmental or medical concerns through the Follow Along Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			80	82	84
Annual Indicator		71.4	81.9	89.1	84.4
Numerator		14000	16450	17753	16622
Denominator		195989	200754	199344	196886
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	88	90	90	90

Notes - 2002

Measure 1 was changed from number of counties to percent of children enrolled in the Follow Along Program.

Web system failure is preventing correct calculation of the annual indicator. The correct indicator is 8.19.

Notes - 2003

The correct annual indicator is 8.91. (Web system failure is preventing correct calculation.)

Notes - 2004

The annual indicator is 8.44. Web system failure is preventing correct calculation.

The numerator represents the number of children active in the Follow Along Program as of June 30th, 2004. Data are provided by local agencies. The denominator is based on vital records for 2001-2003.

This performance measure will be continued with some modification in the next Block Grant cycle.

a. Last Year's Accomplishments

This program improves the chances of identifying developmental problems before the child reaches school age, facilitates early intervention services for the child and links families and children to needed services. This measure assures that in conjunction with newborn screening programs, children are screened both early and continuously for special health care needs. It addresses the state's priorities: "Promote healthy parenting/family development"; "Increase percent of children whose disability is identified early" and "Increase the percent of children who receive early intervention services".

The Follow Along Program (FAP) provides periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems to ensure early identification and services. It is supported programmatically through MCSHN and funded through Title V and Part C of IDEIA at the state level and a combination of Title V and local funds at the local level. The Ages and Stages Questionnaire is the screening tool enhanced to include a social emotional component - the ASQ-SE. Along with ongoing training to local agencies actively engaged in the FAP, training to the Somali Community Screening team on the use of the ASQ and ASQ-SE and to the Department of Human Services and local social services agencies on the use of the ASQ-SE to meet the requirements for mental health screening of children in the child welfare system was also provided. During the 2001 base year the FAP provided screening to 7.1 percent of the children 0-3 years. Active clients on 6/30/2004 were 16,622 or 8.8 percent of the birth to three population.

As of December 2003, .43 percent of infants in Minnesota birth to age one were identified as eligible for Early Intervention services through Part C of IDEA. This compared to .91% nationally. Minnesota identifies 1.43% of infants and toddlers birth to age three as eligible for Early Intervention Services compared to 2.23% nationally. The Office of Special Education Programs (OSEP) has determined the state is not implementing eligibility criteria for services that are consistent with Part C or our approved application. Our partnership with the lead agency (MN Department of Education), requires active involvement in the interpretation of Part C eligibility criteria, re-definition, if necessary, and retraining of local agencies in identifying and serving young children with disabilities.

The MCSHN Information and Assistance Service joined with the MDH Division of Environmental Health (EH) -- Birth Defects Pilot Study to contact the families of all children confirmed as having neural tube defects, cleft-lip/palate or chromosomal anomalies. Once EH confirmed the presence of a birth defect, a MCSHN social worker contacted the family to provide health information and refer to the family to the programs and services available.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide technical support to local public health agencies participating in the program.				X
2. Convene advisory group to guide implementation of program enhancements				X
3. Integrate social emotional component into all screening programs			X	X
4. Continue hosting regional FAP Coordinators Meetings				X
5. Analyze program data & disseminate written report			X	X
6. Provide statewide training on reimbursement & funding sources & effective screening, assessment & intervention			X	X
7. Train professionals including FAP coordinators and Human Services professionals on ASQ-SE				X
8.				
9.				
10.				

b. Current Activities

Early Identification: Follow-Along Program. MCSHN continues to provide technical assistance to local public health agencies through training sessions and software enhancements for the Follow Along Program. New software was released and training was provided throughout the state. Intensive training around the issue of social-emotional development utilizing the ASQ-SE as a tool will continue to be provided to health, education and human services professionals. Early Intervention: Birth Defects Information System. MCSHN is assisting in gearing up for the expansion of the Birth Defects Information System that will include 44 conditions. Part C of IDEIA: MCSHN has continued to work with interagency partners to increase the percentage of young children who receive early intervention services. A particular focus has been participating in evaluating various screening tools for use by local agencies that can be used to identify children who may have a developmental delay.

c. Plan for the Coming Year

A new, but related, priority area "Improve early identification and intervention for children birth to three" was identified in the most recent needs assessment. Three specific areas of activity will contribute to early identification: The Follow-Along Program, the Birth Defects Information System and Child and child find capacity building at the local level for early intervention services through Part C of IDEIA.

State Performance Measure 2: *% of children & adolescent enrolled in health plans for 12 months with no gap > 45 days & who receive nationally accepted standard comprehensive health visits.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	52	54	56	58

Annual Indicator	34.7	36.5	38.3	40	
Numerator	23439	60089	25380		
Denominator	67592	164771	66274		
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	

Notes - 2002

HEDIS 2002 guidelines were used to define both the numerator and denominator. Data for 2001 were supplied by the states' licensed HMOs. Populations represented by the data are fully insured members of HMOs and county-based purchasing entities. Product lines include Commercial, Prepaid Medical Assistance Program (PMAP), and MNCare.

Notes - 2003

The 2003 data are not available

Notes - 2004

The 2004 data are not available. This performance measure will not be continued in the next Block Grant cycle.

a. Last Year's Accomplishments

This performance measure was chosen because periodic visits for infants and annual visits for older children and adolescents is one of the best methods for detection of physical, developmental, behavioral or emotional problems so appropriate treatment can be given, as well as providing opportunities for health promotion and disease prevention and education. This measure serving children and adolescents, is related to priority need "Increase the percent of children whose disability is identified early"; Improve mental health of children, youth and parents"; "Increase the percent of children who receive early intervention services". (Program and Resource Allocation: Direct Services, Enabling services, Population-based Services and Infrastructure Building)

In Minnesota the Title XIX EPSDT program is called C&TC (Child and Teen Check-ups). The percentage of children and adolescents who were enrolled in public programs who received comprehensive, preventive health visits increased by 2% from 2003 to 2004 to a rate of 62%. In general, the data indicate many lost opportunities for the provision of preventive care to these population groups.

Under contract with the Department of Human Services (DHS), Title V staff offered an extensive schedule of C&TC training sessions to health care providers. Participants included public health nurses, private providers, and C&TC Outreach Coordinators. On-site follow-up consultations and clinic flow assessments were provided by a MDH certified pediatric nurse practitioner for newly trained nurses and refresher training was offered to more experienced nurses.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Maintain and monitor as a performance measure for the TANF funded Family Home Visiting Program				X
2. Continue as a joint activity with the DHS as it relates to the Medicaid enrolled children				X
3. Continue to incorporate into WIC & MCSHN clinic activities		X		X
4. Provide technical assistance and training to a variety of key providers			X	X
5. Maintain and enhance partnerships with other organizations who are working to assure child care.			X	X
6. Continue to distribute the Adolescent Health Action Plan: Being, Belonging, Becoming			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Title V continues to collaborate with DHS on the Child and Teen Checkup Program (Minnesota's EPSDT program). Through formal and informal relationships with DHS, Title V provides technical support to public and private Child and Teen Checkup providers, and to Outreach Coordinators in their efforts to inform clients and providers regarding C&TC. Also, Title V provides statewide training for Medical Assistance providers to increase quality comprehensive preventive health visits. Child and Teen Checkup training sessions continue to be updated regularly and are offered for public and private providers focusing on standards and screening components such as anticipatory guidance.

Preventive health care health services, based on the "Guidelines for Adolescent Preventive Services" model, were provided to children and adolescents in community and school-based clinics in Minneapolis and St. Paul. These services reach a population of urban youth who are at high risk for health problems, have inadequate financial access and are underserved in the traditional health care system. Title V funds supported the health services provided to 16,732 children and youth in CY 2004.

Title V continued collaboration with professional organizations, educational programs/institutions, state and local agencies, health plans and related childhood health programs to promote quality preventive care for Minnesota Children. Title V collaborates with the Department of Human Services (DHS) in the planning, development and evaluation of the components and standards for the C&TC. The interagency partnership between Title V, DHS, the Department of Education, and the Minnesota Head Start -- State Collaboration Office has increased efforts to decrease duplication of preventive care and foster coordination between childhood programs that require preventive visits (i.e. C&TC, Early Childhood Screening, Head Start). Activities include joint regional screening workshops and the development of the Minnesota Child Health and Developmental Screening Quality Indicators; A Comprehensive Framework to Build and Evaluate Community Based Screening Systems. To further collaboration regarding comprehensive preventive care, Minnesota was awarded the Maternal and Child Health Bureau's State Early Childhood Comprehensive Systems Planning Grant. The primary goal of the grant is to develop a state plan for an integrated comprehensive early childhood screening system.

Adolescent preventive health services are addressed through outreach and implementation of "Being, Belonging, Becoming: MN Adolescent Health Action Plan" , which includes a focus on strengthening adolescent health care services and systems. Outreach includes technical assistance on use of a youth development framework for addressing adolescent health issues,

information about best practices and health care guidelines, implementation of recommendations for action, and use of available resources to support effective strategies.

c. Plan for the Coming Year

Continue activities currently stated.

State Performance Measure 3: *Incidence of injury (violence/unintended; fatal/nonfatal) to all MCH populations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	310	340	340	340	340
Annual Indicator	334.4	360.5	374.7	363.1	
Numerator	7806	8574	9024	8391	
Denominator	2334659	2378534	2408293	2310771	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	340	340	340	340	340

Notes - 2003

Data for this measure for 2000, 2002 and 2003 have only included cases of deaths and hospitalizations within the MCH population and not cases treated in the ED as originally defined for this state performance measure. ED cases are not a good indication of state performance in addressing injury as they are generally unintentional.

This state performance measure will not be continued in the next Block Grant cycle.

Notes - 2004

This state performance measure will not be continued in the next Block Grant cycle.

a. Last Year's Accomplishments

This performance measure was chosen because unintentional injury and violence are the leading causes of morbidity and mortality in children and youth of both genders, and among women through the age of 34 in Minnesota. Injuries are sometimes the result of inadequate nurturing/supervision of children, unhealthy environments and risk-taking behavior. Injuries are the leading cause of death, hospitalized injury and emergency department-treated injury among children aged 1-19. This measure affects all MCH populations and supports the priority needs "Promote family support and healthy community conditions;" "Reduce youth risk behaviors;" and "Reduce child abuse and neglect." (Program and Resource Allocation: State Level: Enabling Services, Population-based Services, and Infrastructure Services. Local Level: Direct

Health Care).

The incidence of MCH-related injury has ranged from 5,447 per 100,000 in 1998 to 7,358 per 100,000 in 2003 (the year for which most recent data are available). (The incidence rate is calculated by summing fatal and non-fatal hospital-treated (includes hospital admissions and ED-treated outpatients) injury and violence events across all MCH sub-population age groups in the numerator and dividing by the subpopulation total as the denominator.)

For unintentional injury, the principal activity and investment of staff resources have focused on reducing the risk of unintentional injury in homes where young children reside. The Home Safety Checklist is used to identify environmental risks and is the teaching tool for ongoing home monitoring. Other activities include support for community-based activities on the correct use of child restraints in motor vehicles. These activities are supported with Community Health Boards through Title V funding. In 2003, more than 50,000 children were served. The Home Safety Checklist is included as part of the Family Home Visiting Program protocol.

The principal manner of addressing and responding to violence in communities across Minnesota is to train local public health community members to analyze local data, assess community needs, and implement and evaluate control and prevention programs. While "hands on" technical assistance to communities continues to be provided, data and training materials are being disseminated via the web.

The Injury and Violence Prevention Unit maintains the statewide Traumatic Brain and Spinal Cord Injury Registry, the state trauma data bank, the hospital emergency department injury surveillance project, and supports other special injury and violence-related data initiatives. This capacity for data collection and analysis will generate refined performance measurements for each evaluation period.

The MDH Sexual Violence Prevention Program helps to sustain the work of sexual assault programs across the state and, through the state public health system, to build capacity to respond to and prevent sexual violence.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prepare linked data sets to assist partners in understanding county costs of injury/violence			X	X
2. Analyze & disseminate injury & violence mortality data				X
3. Analyze & disseminate injury & violence hospital in-patient data				X
4. Analyze & disseminate injury & violence hospital emergency department data				X
5. Assist & support local public health & other community entities in understanding data			X	X
6. Distribute Sexual Violence Prevention Resource Kits		X	X	X
7. Develop and disseminate training materials			X	X
8. Provide and support the use of the Home Safety Checklist			X	X
9. Use data in developing state policies & programs				X
10.				

b. Current Activities

Bicycle helmet and seat belt use are promoted, smoke alarm installation is encouraged or accomplished, safe storage of firearms is exhorted, and the Home Safety Checklist is utilized among families with young children. These activities also prevent traumatic brain and spinal cord injuries. Title V funds are used to support childhood injury control activities of local public health agencies. Community health professionals use the Home Safety Checklist, analyze local data, assess community needs, and implement and evaluate control and prevention programs. The Sexual Violence Prevention Program offers training and advocacy support, and distributes prevention materials across Minnesota.

State priorities affect the degrees to which communities are able to institutionalize or respond to injury and violence prevention as local public health priorities. In addition, the tenant of honoring local decision-making means that the community may select, in the short term, public health priorities other than those relating to injury and violence prevention. To support local decision-making, the MDH publishes current county level injury and violence data (paper and web-based), which buttress the development of local policies and programs relating to injury and violence prevention.

c. Plan for the Coming Year

MDH Staff will continue to collect, analyze and disseminate data for local and state providers / planners. Data will be disseminated via the web and paper copies. Reports of best practices in the prevention of unintentional injury and youth violence will be distributed and training and technical assistance provided. Emphasis will also continue through C&TC trainings and the Family Home Visiting Program to reduce the incidence of injury in MCH populations

State Performance Measure 4: *Incidence of substantiated child maltreatment by persons responsible for a child's care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.38	7.0	7.5	7.3	7.2
Annual Indicator	8.7	7.7	7.3	6.6	
Numerator	11169	9876	9394	8750	
Denominator	1286894	1286894	1286894	1325744	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.2	7.1	7	7	7

Notes - 2003

Notes for this measure suggest that the numerator includes cases overall and by race and disability statue, but this is inaccurate. It only includes cases overall.

Notes - 2004

The 2004 data are not yet available. This state performance measure will be modified in the next Block Grant cycle to include cases of substantiated and alternative response.

a. Last Year's Accomplishments

This performance measure was chosen because child maltreatment has devastating effects on its victims. While Minnesota's rate of substantiated child maltreatment is relatively low, children with disabilities are nearly twice as likely as their same-aged non-disabled peers to be victims of maltreatment. In addition, there is a 10-fold difference in likelihood of maltreatment between the lowest risk racial group (Asian) and the highest risk racial group (African American). This measure affects children and adolescents and supports the priority to "Reduce child abuse and neglect". (Program and Resource Allocation: Enabling Services; Population-based Services; Infrastructure Building).

a. Annual report: Substantiated child maltreatment by a person responsible for a child's care decreased from 7.3 incidents per 1,000 children (0-17) in 2002 to 6.6 incidents per 1,000 children (0-17) in 2003. In Minnesota, counties have the option to use an alternative response approach to reports of child abuse, whereby they offer a strengths-based response to families needs and provide supportive services. It is a voluntary option for all but the most serious reports of child maltreatment. In 2003 the Alternative Response program was used in 78 of 87 counties, up from 57 in 2002. Approximately 31 percent of all reports were assessed through Alternative Response, up from 22 percent in 2002. No determination of maltreatment is made as part of the Alternative Response assessment.

Child maltreatment has been identified as an important public health issue in the Minnesota Public Health Goals and its associated strategies document. Title V staff provided significant expertise in the development and revision of these documents, and disseminated the information through statewide training and technical assistance to local public health agencies. Title V agency activities have provided technical assistance and consultation for local Community Health Board (CHB) and Tribal Government FHV Program staff for home visiting. In February 2004, FHV staff collaborated with the Infant Mortality Program Coordinator, Injury and Violence Prevention Unit, and the Midwest Children's Resource Center of Children's Hospitals and Clinics to implement a new Shaken Baby Syndrome prevention and education project that provided education for professionals and paraprofessionals via interactive video conference. Parent education materials and education protocols were disseminated throughout the state to local public health and other agencies serving families with newborns. FHV staff participated in planning the 2004 Child Abuse Prevention Conference sponsored by Prevent Child Abuse Minnesota.

Nursing Child Assessment Satellite Training (NCAST) sessions were provided to public health nurses by Title V staff.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain & monitor performance measure for TANF funded Family Home Visiting Program				X
2. Continue involvement on infant/Child Death & Child Maltreatment Review Panels				X
3. Develop/update & distribute infant death investigation guidelines			X	X
4. Provide information to local health & other partners regarding available crisis services				X
5. Disseminate strategies for prevention of child maltreatment i.e., home				

visiting			X	X
6. Continue to provide NCAST training				X
7.				
8.				
9.				
10.				

b. Current Activities

FHV program consultants provide technical assistance and consultation for local public health and tribal government home visiting program staff. Technical assistance and consultation includes site visits upon request, response to ongoing voice mail and e-mail requests, attendance at regional Maternal and Child Health (MCH) Coordinator meetings, determination of training needs and arrangement for trainings via interactive video conferences or live regional trainings.

FHV program consultants assisted in the planning of a two-day Maternal Substance Abuse Training and Forum held on November 8 & 9, 2004. This training was an interagency effort with the Minnesota Departments of Human Services, Health, and Corrections and addressed maternal substance use/abuse and related issues, such as child maltreatment and child protection issues. In January 2005, FHV staff arranged Newborn Assessment trainings in three locations at the request of MCH Coordinators in the southwest counties. Over 90 participants attended the three trainings. In February, March and April 2005, FHV staff participated in planning a series of three interactive video trainings that focused on Methamphetamines and the risks of exposure to pregnant women and children. An afternoon facilitated forum discussion followed each training session to allow for local discussion on the impact of the Methamphetamine problem to local communities. The February Methamphetamine training had over 900 registered participants at 30 sites around the state. In April 2005, Family Home Visiting staff participated in planning the 2005 Child Abuse Prevention Conference sponsored by Prevent Child Abuse Minnesota (PCAMN) and in March 2005, FHV program cosponsored with PCAMN, an interactive videoconference training on Promoting April as Child Abuse Prevention Month. In addition, trainings will be provided for local public health and tribal agency staff on a new curriculum developed by NCAST titled "Promoting Maternal Mental Health During Pregnancy". These trainings will be held the first three weeks of May, 2005, and address the impact that maternal mental health has on the health and well being of children, including intervention strategies to promote positive parenting and prevent child maltreatment. The FHV website includes areas of focus such as: training resources, home visiting strategies and best practices, home safety resources, shaken baby syndrome prevention materials, infant sleep safety educational materials, home visiting guidelines and program reports.

FHV and Infant Mortality staff participates on the Department of Human Services' (DHS) Child Mortality Review Panel. In fall 2004, DHS added staff and began a revision/expansion of their process. They consulted with the National MCH Center for Child Death Review and are implementing training to improve child death reviews at the local level throughout the state. This will enable the state panel to review clusters of similar deaths through a more effici

c. Plan for the Coming Year

Continue activities currently stated. In the current state legislative session, a bill is pending that would expand Shaken Baby Syndrome prevention activities by providing every birthing hospital in the state and all licensed child care providers with prevention videos and printed materials for new parents and child care providers. Staff may be involved with training and curriculum development, dissemination of materials, and reporting requirements of the new legislation. Additionally, prevention of child abuse and neglect was again identified in the MCH Needs Assessment process as one of the top ten priorities for Minnesota for the next five-year cycle of the MCH Block Grant. Performance measures and activities related to these next priorities are

currently being determined.

State Performance Measure 5: *Percent of pregnancies that are unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	43.2	42	41	40	39
Annual Indicator			43.0	43	
Numerator			848		
Denominator			1971		
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	38	38	38	38	38

Notes - 2002
Data are based on PRAMS, which was administered by MN for the first time in 2002. Data is based on 8 months of data collection for that year.

Notes - 2003
The 2003 data are not yet available.

Notes - 2004
The 2004 data are not yet available.

This state performance measure will be continued in the next Block Grant cycle.

a. Last Year's Accomplishments

This performance measure was chosen because pregnancy intendedness is directly related to pregnancy outcome, infant mortality and child health outcomes. This measure affects adolescents and women of child bearing years and supports the following priorities,
· Promote family support and healthy community conditions,
· Promote healthy parenting/family development,
· Reduce teen pregnancies and teen birth rate,
· Address multifaceted needs of teen parents, and
· Reduce youth risk behaviors. (Program and Resource Allocation: Direct Health Care, Enabling Services, Population-based Services and Infrastructure Building).

Baseline data was collected in 1999 as part of the state's Behavioral Risk Factor Surveillance System (BRFSS). Unintended pregnancy was estimated at 43%. Analysis of the 2002 PRAMS data indicates the same. BRFSS will be collecting new information on unintended pregnancy during 2005.
Title V, Title X, and state funds are expended for family planning services, including method

services. In 2003, local CHBs used $756,000 to deliver method services to 3,180 individuals. In 2004, Title X funds of $180,000 were used to deliver method services to 1,631 high-risk adolescents, and $4.9 million in state dollars supported methods services for 25,692 individuals.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze PRAMS data				X
2. Ensuring efficient & effective use of state funds ($3.7 million) a year for family planning services	X	X	X	
3. Target Title X funds to high-risk minority teens	X		X	X
4. Partner with Department of Human Services to successfully implement 115 Waiver for family planning	X		X	X
5. Increase public understanding & support for policies & programs that reduce unintended pregnancies			X	X
6. Develop public understanding & support for policies & programs that reduce unintended pregnancies			X	X
7. Promote statewide implementation of abstinence based education for 12 to 14 years old			X	X
8. Implement youth activities that increase resiliency & support healthy behaviors			X	
9. Continue to direct resources to a hotline for family planning & STI services	X	X	X	X
10. Support school-based clinics & advocate for comprehensive reproductive health education	X	X	X	X

b. Current Activities

Title V, Title X and state funds continue to support family planning services. During the 2003 legislature, the legislature reduced state family planning funds by $1.2 million, to $3.7 million, beginning in SFY 2005. Federal approval for Minnesota's 1115 Family Planning waiver application was received in July 2004. Implementation is planned for July 2006. The waiver will allow individuals with incomes up to 200 percent for FPG to obtain fee-for-service coverage of family planning services.

c. Plan for the Coming Year

Continue current activities as stated. In partnership with the Minnesota Department of Human Services and other stakeholders, planning for implementation of the 1115 Family Planning waiver will be a major focus of program activity this year. In order to maximize the effectiveness of the 1115 waiver, continuation of Title V, Title X and state-funded family planning activities will be needed.

State Performance Measure 6: *Percent of women who use alcohol, tobacco and other drugs during pregnancy*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12.1	12.1	12	11.1	11
Annual Indicator	12.1	12.4	11.1	10.0	
Numerator	7496	7361	7337	6713	
Denominator	61800	59324	66111	66805	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10.5	10.5	10	10	10

Notes - 2003

Contrary to the definition of this state performance measure, the annual indicator represents only the percent of women who use tobacco during pregnancy. Data are from birth records, which are known to greatly underestimate the true rate of tobacco, alcohol and other drug use during pregnancy.

Notes - 2004

This state performance measure will not be continued in the next Block Grant cycle.

a. Last Year's Accomplishments

This performance measure was chosen because health professionals concur that tobacco, alcohol and other drug use during pregnancy is injurious to the fetus and profoundly affects pregnancy outcomes. This measure affects all women, especially pregnant women and supports priority needs: " Reduce drug, alcohol and tobacco use" and Reduce youth risk behaviors". (Program and Resource Allocation: Enabling Services; Population-based Services; and Infrastructure Building).

Title V staff were involved in a number of activities intended to reduce alcohol, tobacco, and other drug use during pregnancy, including: 1) Analysis of the Minnesota Pregnancy Assessment Form (MPAF). This form asks providers to assess medical and psychosocial factors that contribute to poor birth outcomes. Among the 40 items assessed are questions regarding tobacco, alcohol, and/or other drug use during pregnancy. Since June 1998 the Department of Human Services has required all pregnant women covered by Medical Assistance and/or MinnesotaCare to be screened using the (MPAF) to be reimbursed for prenatal care services. It is estimated that of the 22,692 deliveries in 2001 covered by Medical Assistance, 16,537 or 72.9 percent, were screened prenatally using the MPAF. 2) Activities of the FAS Program have primarily concentrated on intervening in women's alcohol use in pregnancy around the state. The three major components of this effort include a grants program, a mandated professional education and curricula development project, which has been completed, and a public information and media campaign, completed in 2003. 3) The results of a needs assessment prompted MDH to subscribe to a clinician's toll free phone line for information about patient drug exposure, prenatal exposures to alcohol and other chemicals, and pregnancy management advice. 4) MCSHN offered a number of statewide Developmental Behavioral diagnostic clinics, with providers trained specifically to diagnose

FAS/FAE. 5) Staff has developed a Women and Substance Use in the Childbearing Years Prevention Primer. The Primer is a new tool to prevent the devastating effects of alcohol, tobacco and other drugs on women and children. Developed by public health educators and nurses. It serves as a guide for client and community prevention educators and planners in a variety of practice settings. It encompasses risk factors such as domestic and sexual abuse and mental health issues and how they intersect with substance use/abuse. It is both a compendium of recommended education resources and a prevention planning guide. 6) The Department received a 5 year CDC grant in October, 2003, for FAS Prevention and has been working to implement the grant duties. The purpose is to increase Minnesota's capacity to integrate targeted and population based alcohol and contraception screening and behavior change interventions for women of childbearing age in select community settings; to reduce binge and prenatal drinking.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue use of the MN Pregnancy Assessment Form			X	X
2. Enhance data collection and interpretation of MN Pregnancy Assessment Form			X	X
3. Work toward data matches between MN Pregnancy Assessment From (Medicaid) & Birth & Death records				X
4. Begin to analyze PRAMS data			X	X
5. Continue implementation & evaluation of FAS prevention activities.	X	X	X	X
6. Provide technical assistance to community FAS service providers & grantees				X
7. Create and maintain a statewide partnership of organizations addressing tobacco cessation for women of childbearing age.			X	X
8. Provide Teratogen info & management line for state clinicians			X	X
9. Increase provider education & dissemination of tools for smoking cessation during pregnancy			X	X
10. Develop integrated assessment in WIC clinics & Family Home Visiting Program	X		X	X

b. Current Activities

Staff are currently 1) disseminating best practice information and resources to local public health, WIC clinics, tribal health, community-based organizations, and providers to help pregnant women stop smoking, prevent post partum relapse, and encourage use of Minnesota's telephone QuitPlan. 2) C&TC provides Child and Teen Checkup (EPSDT) training sessions with instruction on health history questions specifically regarding alcohol, tobacco and other drug use. 3) Transitioning FAS training curricula to the web. 4) Continue to collaborate with others to assure an integrated statewide system of partnerships and services aimed at reducing the number of pregnant women who use or abuse chemicals during pregnancy. 5) Participate on the project "Reducing Tobacco Abuse Among Pregnant American Indian Women" lead by the Indigenous People's Task Force. This project combined existing quantitative data from birth certificates and the WIC program with qualitative data generated by community researchers in order to determine what contributes to the apparent high smoking rate of pregnant American Indian women and what strategies the community could use to reduce that rate. 6) In early 2004, staff was invited to apply for technical assistance from AMCHP, ACOG, PPA, and the CDC to create a state partnership on smoking prevention and

cessation for women of reproductive age. Minnesota's application was selected and a state team including the Title V staff team leader, staff from MDH's Tobacco Prevention and Control Section, the state chair of ACOG, and the policy director of Planned Parenthood of MN/SD attended the training in Washington, DC and developed a state partnership plan. Implementation of this plan is beginning. 7) Monitor and provide technical assistance to FAS grantees. 8) Conducted 57 Developmental Behavioral evaluation clinics in 12 out-state cities. 9) Public information efforts focused on messages for populations of color. Focus group research led to development of the campaign's creative concept "Drinking during pregnancy is a risk to a woman's health and her baby's health. Are you willing to take that risk? Help pregnant women stop drinking during pregnancy because the stakes are too high." 10) Disseminating the Women and Substance Use in the Childbearing Years Prevention Primer described above. 11) Work continues on the implementation of the CDC grant for FAS prevention: Incorporation of FAS into the birth defects information system; partnership with a family planning clinic to support education and contraceptive use for women who drink; targeted public education, awareness, and screening.

c. Plan for the Coming Year

Reorganization of work units within the MCH Section resulted in a Perinatal Health Unit whose primary responsibility is to implement the activities described in the plan. This unit will integrate the activities of the Infant Mortality Reduction Initiative, Family Home Visiting, preconception health, and behavioral health including reducing and preventing substance use/abuse in pregnancy and will work across units with the Reproductive Health Team to reduce unintended pregnancies and improve women's health. Continue activities currently stated.

State Performance Measure 9: *Rate per 1,000 children with disabilities who are in out- of-home placement due to disabilities.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			9	9	9
Annual Indicator	3.2	9.1	9.7	8.0	
Numerator	206	588	623	549	
Denominator	64345	64345	64345	68682	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	9	9	9

Notes - 2003

Unique children all episodes of entering care. Denominator is 5.5% of the 2002 estimated population under 18 years of age. Indicator is the rate/1,000 children with disabilities.

Notes - 2004

Data for 2004 are not yet available. This state performance measure will not be continued in the next Block Grant cycle.

a. Last Year's Accomplishments

his performance measure was chosen because one of the ongoing significant goals for children's programs in Minnesota has been the development of a community-based, family-centered system of care for children with chronic illness and disabilities. We believe that children with disabilities belong in loving families in their own communities and that federal and state resources should be made available to support families in their efforts to maintain their children at home. Over the last 3 years, many of the state and federal resources used to support these efforts have been threatened. This measure affects children with special health care needs and supports the state's priority needs: "Promote family support and healthy community conditions"; Promote healthy parenting/family development"; "Reduce child abuse and neglect"; and "Improve mental health of children, youth and parents". (Program and Resource Allocation: Direct Health Care, Enabling Services; Population-based Services and Infrastructure Building).

The rate of children entering out of home placement due to a disability decreased slightly, withstanding systems trends that would be expected to have caused an increase. Children with special health needs, once placed out of home are significantly less likely to return to their families than their healthy peers. The most recent data available for 2004 indicate that the rate of children entering in out-of-home placement due to a disability is 7.9/ 1000 disabled children. This compares to 9.1/1000 in 2001, 9.7/1000 in 2002, and 8.5/1000 in 2003.

MCSHN staff continued to ensure families and care coordinators are aware of and understand how to access services and supports to assist families in maintaining their children at home. 1,445 parents and professionals attended MAZE workshops and were provided with training and technical assistance materials designed to clarify funding streams for community-based services. MAZE materials were modified to reflect legislative changes that impacted services and systems. Staff continued leadership roles in the development and implementation of a coordinated, interagency birth -- 21 system of services for children with disabilities. On-going assistance in locating services and supports was provided to nearly 600 parents and a variety of professional through the Information and Assistance line. The web-based Central Directory of Early Childhood Services received an average of 2,050 hits per quarter last year and the document was downloaded in its entirety an average of 407 times each quarter. Over 200 hard-copy versions of the Directory were sent out each quarter.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prepare & distribute MAZE training materials for use in local agencies.				X
2. Assure that families have access to the support services they need.		X	X	X
3. Continue the MCSHN 1-800 number to assist families in locating services.	X	X		X
4. Assure that families have a coordinated plan of care through the IIIP.		X	X	X
5. Update SSI outreach materials			X	
6. Prepare and disseminate written information to families identified through the BDIS		X	X	
7.				

8.				
9.				
10.				

b. Current Activities

MAZE trainings will continue throughout the coming year with revisions as needed after the legislative session ends in May or June. The Information and Assistance line will continue to be available to families who need support in locating community-based services for their children. Expansion of outreach to families identified through the Birth Defects Information System (BDIS) due to expansion of the number of conditions being identified is being planned. Materials describing resources available to very young children with identified conditions have been developed and will be distributed. Outreach materials for individuals applying for SSI will be revised to assure families know how to contact the MCSHN Information and Assistance phone line so they can be linked to needed services.

c. Plan for the Coming Year

Most, if not all, of the current activities will be carried over to FFY2006. MAZE materials will continuously be updated; the Central Directory is updated continuously and services added as they become available. Information and Assistance activities will continue as well as efforts in the interagency coordination process to increase the number of children who have an Individual Interagency Intervention Plan. The performance measure itself is being replaced due to changes in priorities, as a result of the 2005 Needs Assessment.

State Performance Measure 10: *The percentage of children birth through 21 years of age eligible to have an Individual Interagency Intervention Plan (IIP) who have a IIIP.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				11	12
Annual Indicator			10.6	10.6	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	14	15	15	

Notes - 2002

New Performance measure data not yet available.

Notes - 2003

2002 denominator was based on a synthetic estimate found to have been in error. No data is available for FY 2003. Beginning 9/1/2004 actual numbers will be tracked by the Department of Education.

Notes - 2004

Data for 2004 are not available. This state performance measure will not be continued in the next Block Grant cycle.

a. Last Year's Accomplishments

This performance measure was chosen because it supports a coordinated family centered community based system of care. This performance measure supports the state's priority need "Promote family support and healthy community conditions" and "Increase the percent of children who receive early intervention services". (Program and Resource Allocation: Population-based Services, Infrastructure Building).

This performance measure was developed prior to the implementation of the six core outcomes for CYSHCN. It relates most specifically to services being organized for ease of use. At the suggestion of the Project Officer at the last federal Title V Block Grant review, this performance measure is inactivated until such time as MNSIC is fully implemented and data are more reliable. During FFYs 2001 and 2002 a major effort was undertaken to develop a system of interagency coordination of services for children with disabilities. Modeled after the state's experience with Part C and the Individual Family Service Plan for children 0 to 3, the IIIP is targeted for children receiving Special Education Services and services from another state agency. Beginning in 2000 and 2001, IIIPs were developed for children with a special health care need birth to 5 and then expanded to children birth to 9. As of July 1, 2003 the IIIP is available to children up to age 22. It is voluntary on behalf of both families and local agencies. For annual report 2004, see NPM#5.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop needed policies to implement legislative requirements				X
2. Provide technical assistance & training to local county & state agency personnel			X	X
3. Fully participate & staff MnSIC advisory groups, work groups, & State Interagency Committee				X
4. Develop & print needed written manuals on system components & intra-agency coordination				X
5. Develop evaluation strategies, indicators & methods for implementation at state & local levels			X	X
6. Assure that local public health is fully participating in plan development				X
7. Promote utilization of III-P among families, special ed teachers, and county social service personnel.		X	X	X
8.				
9.				
10.				

b. Current Activities

See NPM #5.

c. Plan for the Coming Year

Discontinued as a state performance measure due to revised priorities from the 2005 Needs Assessment activities.

E. OTHER PROGRAM ACTIVITIES

Toll-free Telephone Numbers - For parents and others, the Minnesota Title V programs assure toll-free telephone access to information about health care providers and practitioners who provide health care services under Titles V and XIX SSA and about other relevant health and health-related providers and practitioners. MDH has worked to accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free arrangements.

1. The Title V MCSHN Section has operated a toll-free Information and Assistance telephone line since March of 1990. The toll-free number is 800 728-5420. This line offers a comprehensive listing of services provided by state and county health and human services departments, hospitals, associations, family support groups and allied public and private entities. The toll-free number is included on all educational and informational publications developed and distributed by MCSHN and is included in all media announcements.

2. Minnesota does not have a dedicated 800 number for questions related to prenatal care or pregnancy. The Department of Human Services (DHS) consumer services call center 800 number handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Calls related to prenatal health programs and other maternal and child health matters are referred to Title V. Information regarding obtaining prenatal services and related questions can also be accessed via the MDH or DHS internet web sites.

3. The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The automated message is available in seven languages including Spanish, Hmong, Somali, Vietnamese, Laotian, Bosnian, and Russian. The number is (651) 297-3862 (metro) and 1-800-657-3672 (greater Minnesota). The toll-free number will provide the caller with general information about the plan, qualifications for acceptance, and application information. All outreach materials distributed by the Department of Human Services include this state toll-free number for clients to call with questions. The line handle about 200,000 calls per year.

4. The Minnesota Family Planning and STD hotline is funded through state appropriations. The hotline is staffed by individuals trained in information and referral as well as family planning and STD counseling. The number is 800-78-FACTS. In 2003, approximately 4,900 calls were handled by the hotline. All family planning and STD related educational materials distributed by the Minnesota Department of Health include the hotline number. Annually, a pamphlet about family planning, which includes the hotline number, is mailed to all Medicaid recipients.

5. The WIC Program (Women, Infants and Children) 800 number is funded through Minnesota's federal WIC grant and provides 24 hour - 365 days a year phone coverage. Callers to the WIC 800 number are provided with the business telephone number of the local WIC project in their geographic area. The toll-free number is 800-WIC-4030. The service responds to approximately 3,300 calls per year. All WIC outreach materials distributed by the state WIC office and the local projects include the 800 number. There is also a WIC supported specialized line related to breastfeeding (877-214-BABY).

6. The Minnesota Immunization Hotline was established in 1994 and operates between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday. The toll-free number is 800 657-3970. The Hotline is staffed by a team of nurses and other professionals highly-trained in immunizations. Its primary purpose is to provide a timely source of information and consultation for providers and consumers

faced with the increasing complexities of immunizations.

F. TECHNICAL ASSISTANCE

Discussions are underway regarding several options for possible technical assistance requests, but we do not have a specific request at this time. We will be able to update the HRSA project officer on this at the block grant review in August.

V. BUDGET NARRATIVE

A. EXPENDITURES

The expenditures are described in Forms 3-5.

B. BUDGET

Variations of 10 percent or more between budgeted amounts and expended amounts have been noted on the note sections of Forms 3-5.

Other sources of federal funds come from HRSA, including the Maternal and Child Health Bureau (MCHB), the Centers for Disease Control and Prevention, the Department of Agriculture, and the Department of Education. MCHB supports the State Systems Development Initiative, Abstinence Education, Genetics, Universal Newborn Hearing and Screening, and Medical Home Development programs. The Centers for Disease Control and Prevention funds the Preventive Block Grant, the Pregnancy Risk Assessment Monitoring System (PRAMS) project, Universal Newborn Hearing Screening and FAS activities. The Department of Agriculture supports the Supplemental Nutrition Program for Women, Infants and Children (WIC) program and the Commodity Supplemental Food Program (CSFP). The Department of Education funds the Part C program.
It should be noted that while the Division of Community and Family Health is the recipient of all the funds described above, not all of the funds are administered by the MCH or MCSHN Sections. However, all the funds impact the MCH population and are under the control of the Community and Family Health Division Director.
The sources of matching funds include the state General Fund, the greatest of which include state Local Public Health Grant and local tax revenues. State General Fund dollars also support additional MCH-related activities such as the Infant Mortality, MCSHN clinics, the Fetal Alcohol Syndrome Initiative, the Family Home Visiting Program, Suicide Prevention, and Family Planning.

Minnesota's maintenance of effort from 1989 is $6,184,197. The budget documents that Minnesota has exceeded this level of effort.

The Minnesota legislature did not complete the work necessary during the regular legislative session to allot budgets for all state agencies. The Governor called for a special session to extend the timeframe for their work, but at this time the necessary agreements have not been reached and there may be a partial shutdown of state government starting 7/1/2005. With the outcome of this legislative session yet unknown, there maybe additional changes in state funding to Title V related programs. We will not know this until the legislature finalizes the budget for this next biennium.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.